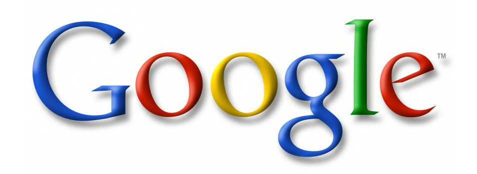










V. Internationaler Dermatologen-Kongress

abgehalten

in Berlin vom 12.—17. September 1904.

Verhandlungen und Berichte

herausgegeben von

Sanitätsrat Dr. **O. Rosenthal,**
General-Sekretär.

I. Band.

Berlin 1904.
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Vorwort.

Auf eine Anregung aus dem Preussischen Kultusministerium wurde den drei vom Organisations-Komitee aufgestellten Hauptthemata Ende vorigen Jahres die Leprafrage hinzugefügt. Um ein möglichst vollständiges Bild der seit der internationalen Leprakonferenz im Jahre 1897 erfolgten Fortschritte auf diesem Gebiete zu gewinnen, wurden Vertreter aller beteiligten Länder aufgefordert, „über den Stand der Verbreitung und der Bekämpfung der Lepra seit der I. Internationalen Leprakonferenz im Jahre 1897“ einen Bericht zu geben.

In dem Bestreben, eine Einheitlichkeit in der Berichterstattung zu erreichen, wurden die Herren ersucht, sich an das folgende, von Herrn Prof. v. Petersen in St. Petersburg vorgeschlagene Schema, soweit tunlich, halten zu wollen:

I. Statistik
  a) nach offiziellen Berichten,
  b) der Asyle, Kolonien (Form, Geschlecht, Alter).

II. Massregeln zur Bekämpfung der Lepra von 1897—1903 (inkl.)
  a) Regierungsverordnungen,
  b) Tätigkeit der Regierungsorgane, Kommunen resp. Gesellschaften u. s. w. zur Bekämpfung der Lepra:
    1. Zahl der Asyle oder Kolonien,
    2. Zahl der Plätze,
    3. Krankenbewegung,
    4. Beschäftigung der Leprösen in Anstalten,
    5. Transport der Leprösen in die Anstalten per Eisenbahn resp. Dampfer.

III. Die Lage der Leprösen in den Hospitälern und Kliniken.

Die Resultate dieser, wie man aus den nachfolgenden Berichten ersieht, mit grösstem Eifer und Interesse erstatteten Arbeiten liegen in diesem Buche vor, welches als der erste Band des Berichtes über

die Verhandlungen des V. Internationalen Dermatologen-Kongresses erscheint. Die Lücken, welche durch das Fehlen einiger weniger Länder entstanden sind, wurden zum Teil dadurch veranlasst, dass bei der Kürze der Zeit und der Entfernung der Länder es nicht immer möglich war, den geeigneten Mitarbeiter zu finden oder zu erreichen. Einige kleinere Berichte stehen noch aus und konnten diesem Bande nicht mehr hinzugefügt werden, weil sie zu spät eingegangen sind. Dieselben werden im Anschluss an das von Herrn Geh. Medizinalrat Prof. Dr. A. Neisser über die Leprafrage zu erstattende, zusammenfassende Generalreferat in dem zweiten Bande der Verhandlungen erscheinen.

Allen Herren, welche dazu beigetragen haben, die Herausgabe dieses Teiles des Berichtes in so kurzer Zeit zu ermöglichen, sei an dieser Stelle der herzlichste Dank ausgesprochen.

Berlin, den 1. September 1904.

Der Generalsekretär.

Inhaltsverzeichnis.



Belgien und Congo.

Bericht

von

Dubois-Havenith in Brüssel.

Belgique.

Comme le Dr. Bayet l'a signalé déjà dans son rapport à la Conférence de Berlin en 1897, la lèpre n'existe pas en Belgique, en tant que maladie autochtone.

Les quelques rares cas qui y ont été observés étaient de provenance étrangère.

C'est dire qu'il n'y a en Belgique ni statistique officielle, ni mesures prophylactiques relativement à cette maladie.

Etat Indépendant du Congo.

Si la lèpre s'observe au Congo, il résulte des renseignements recueillis dans les Bureaux mêmes du Gouvernement de l'Etat Indépendant, qu'elle y est très-rare.

D'après le Dr. Van Campenhout, professeur d' Hygiène à l'Institut Colonial et médecin de l'Etat Indépendant du Congo, les indigènes isolent les lépreux et évitent tout commerce avec eux.

Quand un cas se produit dans les postes de l'Etat, il est immédiatement isolé. Mr. Van Campenhout a observé des cas de lèpre manifestes dans l'Ouellé, dans la Likati et le long du Haut-Congo; mais il n'a jamais eu l'occasion de faire un diagnostic bactériologique.

Il n'existe ni statistique, ni mesures officielles ou autres.

Conclusion: La lèpre est très-rare au Congo et n'y paraît pas en progrès; du moins aucune aggravation ni dissémination inquiétantes n'ont été signalées par les médecins qui exerçent au Congo.

Bulgarien.

Bericht

von

Béron in Sofia.

Wie aus unserer Mitteilung von der ersten Lepra-Konferenz zu ersehen ist, waren in Bulgarien bis 1897 nur 2 Lepröse bekannt. Seitdem sind noch 10 klinisch und bakteriologisch diagnostizierte Fälle beobachtet worden, so dass die Zahl der Leprösen bis Ende 1903, nach unserer Privatstatistik, auf 12 gestiegen ist, wovon 9 von uns persönlich teils im Alexander-Spital, teils privatim untersucht worden sind und 3 sind von verschiedenen Aerzten in den Provinzspitälern beobachtet worden. Von den 12 Leprakranken (1 Frau und 11 Männer) leiden 3 an reiner Lepra nervorum und 9 an Lepra tuberosa et maculo-anaesthetica. Dem Alter nach verteilen sich die Kranken wie folgt: Vom 15.—20. Lebensjahre sind 2; vom 30.—40. = 2; vom 40.—50. = 6 und vom 50.—60. Lebensjahre 2; der jüngste Lepröse ist 16 Jahre und der älteste 60 Jahre alt.

Ohne Zweifel ist die Zahl der Leprösen in Bulgarien eine bedeutend grössere, denn die bis jetzt bekannten Fälle entstammen verschiedenen Bezirken, haben nie mit einander verkehrt und die meisten haben das Land nicht verlassen und müssen folglich die Krankheit im Lande selbst, also von anderen noch unbekannten Leprösen bekommen haben. Anderseits ist die Krankheit unsern Aerzten noch nicht genügend bekannt und nach unserer Erfahrung bezüglich der bis jetzt bekannten Fälle werden höchstwahrscheinlich manche Leprakranke in den Statistiken als syphilitische, sarkomatöse etc. geführt.

Es gibt in Bulgarien keine speziellen Lepraasyle; die Kranken leben unter der Bevölkerung und sind keiner besonderen Kontrolle unterworfen.

Die einzige zur Bekämpfung der Lepra ergriffene Massregel ist die seit vorigem Jahre (1903) gesetzlich eingeführte unentgeltliche ambulatorische und Spitalbehandlung der Leprakranken.

China.

Bericht

von

G. Velde in Charlottenburg.

Im Jahre 1897 war durch den Kaiserlichen Gesandten in Peking der chinesischen Regierung eine Einladung zur Beschickung der Lepra-Konferenz zugestellt worden. Wie aus der einige Monate später mitgeteilten Antwort hervorgeht, war diese Einladung nicht für Gelehrte und höhere Verwaltungsbeamte aufgefasst, sondern an die Provinzialgouverneure weiter gegeben worden, die sie ihrerseits fast allenthalben durch Maueranschläge dem chinesischen Volke bekannt machten. Infolgedessen war China bei der Konferenz überhaupt nicht vertreten.

Die gedruckten Verhandlungen der Lepra-Konferenz enthalten nur wenige unübersichtliche Angaben über die Verbreitung der Lepra in China, und zwar hauptsächlich die Bemerkungen des Herrn Emile Raemdonck: La lèpre en Asie centrale. Von einigen Einzelheiten abgesehen, geht aus den kurzen Angaben des Père Raemdonck nur hervor, dass nach den Erzählungen der katholischen Missionare die Lepra-Erkrankungen in Südchina häufiger sein müssen als im Norden.

In den allgemeinen Bemerkungen über die Geographie der Lepra von Kübler (Verhandlungen, Bd. III, S. 3) findet sich ferner die Bemerkung: „In China sind nach A. v. Bergmann die südlichen und östlichen Provinzen vornehmlich betroffen, in Hongkong soll die Krankheit nicht häufig sein“.

Diese dürftigen Nachrichten über Lepra in China hatten eine Erweiterung erfahren durch einen Bericht, den Referent im Jahre 1899 im Auftrage der Kaiserlichen Regierung über diesen Gegenstand erstattet hat (abgedruckt in „Arbeiten aus dem Kaiserlichen Gesundheitsamt“, Bd. XVII, Heft 2). In demselben waren berücksichtigt die Berichte der von der Verwaltung der chinesischen Seezölle angestellten Aerzte in Medical reports, published by order of the Inspector General of Customs, 1st—55th Issue, Notizen in China Medical Missionary Journal, Shanghai, die Reports of the Medical Missionary Hospital at Swatow, das Werk von James Cantlie, Leprosy in Hongkong, sowie Auskünfte der in China ansässigen deutschen Aerzte und deutschen Konsuln. Ueber Peking und Umgebung selbst stehen dem Referenten 4jährige eigene Erfahrungen, über die Provinz Shantung eigene Beobachtungen auf einer

zu diesem Zweck unternommenen Reise durch die ganze Provinz im Jahre 1898 zur Verfügung.

In einem Lande, von dem die Ziffer der Bevölkerung nur schätzungsweise bekannt ist, in dem ansteckende Kranke überhaupt keiner Kontrolle unterworfen sind, und in dem die einheimischen Behörden Massregeln gegen ansteckende Krankheiten für gewöhnlich nicht zu treffen pflegen, ist es naturgemäss schwierig, zuverlässige Angaben über die Zahl der vorhandenen Leprakranken zu erhalten. Die geringe Zahl der in China vorhandenen europäischen Aerzte, von denen sich wieder nur ein kleiner Teil mit der Behandlung von Eingeborenen beschäftigt, ermöglicht einigermassen zuverlässige Beobachtungen nur für ganz umschriebene Gebiete. Die chinesischen Aerzte stossen bei der Erkennung der Krankheit mangels genügender Ausbildung auf die grössten Schwierigkeiten. Die Verwendung ihrer Angaben ist ferner noch dadurch erschwert, dass sie sich verschiedener Bezeichnungen für diese Krankheit bedienen. Die Zusammenstellung der auf diesem Wege gewonnenen Ergebnisse besitzt daher nur einen bedingten Wert; sie mag im grossen und ganzen ein zutreffendes Bild geben, kann aber hinsichtlich der Einzelheiten nicht Anspruch auf unbedingte Richtigkeit erheben. Bei der Unmöglichkeit, andere Angaben zu erhalten, dürfte aber auch eine solche Zusammenstellung berechtigt sein.

Von den 18 Provinzen Chinas lagen überhaupt nur aus 10 Nachrichten vor, die sich im wesentlichen auf die Verkehrszentren erstreckten, aber auch teilweise Angaben über das platte Land enthielten. Aus ihnen ergibt sich, dass am stärksten befallen sind die Provinzen Kwantung, Fukien und der südliche Teil von Yunnan (südliche Provinzen), sowie die am unteren Laufe des Yangtsekiang gelegenen Provinzen Hupe, Anhui und Kiangsu. Die Zahl der Leprösen mag hier etwa 1 ‰ der Bevölkerung betragen. Weniger stark befallen sind die übrigen südlichen Provinzen, nahezu frei von Lepra sind die nördlichen einschliesslich Schantung.

Geschlecht und Lebensalter haben auf die Verbreitung der Lepra in China keinen Einfluss, wohl aber die sozialen Verhältnisse. Zwar sind die wohlhabenden Klassen keineswegs gänzlich frei, doch gehört die grosse Mehrzahl der Leprösen den allerärmsten Klassen der Bevölkerung an. Die ungünstigen Wohnungsbedingungen — häufig hausen ganze Familien von 8 bis 10 Köpfen auf einem kleinen Kahn — erleichtern die Uebertragung innerhalb der Familie. Europäer erkranken in Ostasien nur ausnahmsweise an Lepra, weil sie zu den Kreisen, in welchen die Krankheit besonders verbreitet ist, kaum in Beziehung treten.

Wie lange schon Lepra in China herrscht, lässt sich nicht mit Sicherheit feststellen. Die ältesten Nachrichten behandeln epidemisches Auftreten der Krankheit in den Jahren 1417 und 1589.

In der Mitte des 17. Jahrhunderts wurde für ganz China gesetzliche Fürsorge für Kranke, Blinde und dergl. getroffen. Diese Massnahmen haben nur im Süden, insbesondere in der Gegend von Canton, Anwendung auf Lepröse gefunden und besagen, dass sie in hinreichender Entfernung von bewohnten Plätzen abgesondert sich aufhalten und ihren Unterhalt aus öffentlichen Mitteln erhalten

sollen. Da der gewährte Betrag von monatlich etwa 25 Pfennig und 10 kg Reis zum Lebensunterhalt nicht ausreicht, gehen die Kranken aus den ihnen zugewiesenen Wohnsitzen zum Zweck des Bettelns nicht nur nach den benachbarten, sondern vielfach auch nach ganz entfernten grossen Städten. So soll der grösste Teil der in Shanghai befindlichen Leprakranken aus den südlichen Provinzen stammen. In der Umgegend von Canton befinden sich abgesonderte Wohnplätze für etwa 350 Lepröse. Die Zahl der vorhandenen Kranken ist aber erheblich grösser. Die unzulängliche Fürsorge veranlasst sie häufig Ausschreitungen zu begehen, um sich in den Besitz von Nahrungsmitteln zu setzen; nur zu leicht wird so der Hass der Bevölkerung gegen diese Unglücklichen erregt, die durch Verbrennen oder dergl. aus dem Wege geräumt werden.

Die Annahme der Uebertragbarkeit der Lepra, von der die gesetzlichen Bestimmungen ausgehen, wurzelt auch im Volksbewusstsein. So erkundigen sich vor der Aufstellung von Heiratsverträgen in Lepragegenden die beiden beteiligten Familien eingehend, ob unter den Mitgliedern oder Vorfahren der anderen Partei Lepra vorgekommen ist.

In der englischen Kolonie Hongkong werden alle der Lepra Verdächtigen einer eingehenden ärztlichen Untersuchung unterworfen. Krankbefundene werden unter Gewährung eines bescheidenen Reisegeldes ausgewiesen. Auf diese Weise hat sich die Stadt, ungeachtet ihrer zahlreichen und äusserst schlecht untergebrachten Chinesenbevölkerung, frei von Lepra gehalten. Im deutschen Bezirk Kiautschou werden die wenigen Leprakranken, die zur Beobachtung kommen, sofort abgesondert. Die übrigen europäischen Niederlassungen in China haben soweit bekannt keine besonderen Vorkehrungen gegen die Einschleppung der Lepra getroffen.

Durch Einwanderung chinesischer Arbeiter ist die Lepra nach San Francisco und vor allem nach Hawaï gebracht worden. Da die gegenwärtigen Kulitransporte nach Holländisch-Indien und die beabsichtigten Transporte nach Südafrika und nach Samoa fast ausschliesslich aus Swatow kommen, einer Gegend, die zu den am stärksten von Lepra befallenen in China gehört, so ist die Gefahr einer Verschleppung der Krankheit dauernd recht beträchtlich. Für die nach deutschen Bezirken gehenden Kulitransporte sind deshalb ärztliche Untersuchungen angeordnet, die sich neben der Feststellung ansteckender Krankheiten überhaupt auch auf Lepra erstrecken. Es ist anzunehmen, dass die englische Regierung für die nach Südafrika bestimmten Leute gleichartige Massnahmen treffen wird.

Chile.

Bericht

von

Carlos Ybar in Santjago.

In Chile hat man bisher nur sehr wenige Fälle von Lepra beobachtet, und kennt man nur drei, welche unter Isolierung beobachtet sind. Von anderen Fällen hat man nie gehört, sei es, dass keine weiter vorhanden waren, oder sei es aus Mangel an Kenntnissen in der Dermatologie, welche bis vor wenigen Jahren sehr unzulänglich hier zu Lande waren.

Am 23. Juni 1898 kam ein Leprafall[1]) in Valparaiso vor. Der

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1) Anmerkung: Um die Folgerungen, welche man aus dieser Arbeit ziehen wird, richtig zu schätzen, halte ich es für notwendig, von zwei vorhergehenden Leprafällen, welche vor dem Jahre 1897 auftraten, zu sprechen, obgleich ich Gefahr laufe, die mir gezogenen Grenzen zu überschreiten.

Dr. Louis Frömel berichtet in einer Abhandlung an den „Consejo Superior de Hijiene“ von zwei Leprakranken, welche von ihm behandelt wurden.

I. Fall: N. N., Apotheker, ansässig in San Felipe, Chile. — Derselbe war nie ausserhalb Chile gewesen, war zweimal verheiratet und hatte gesunde Kinder. Er spürte die ersten Symptome im Jahre 1887 und starb 1891; es ist hierbei besonders zu bemerken, dass der Kranke Chile nie verlassen. — In diesem Falle handelte es sich um „Lepra maculo-tuberosa anaesthetica“.

Da nun San Felipe die Durchreisestation für die vielen Reisenden ist, welche von Argentinien über die Cordilleren nach Chile kommen, so ist es möglich, dass N. N. in direktem Umgang mit Personen aus Ländern, in denen die Lepra herrscht, angesteckt ist.

II. Fall: Dieser zweite Fall, von dem Dr. Frömel berichtet, trat im Jahre 1895 auf. Ein Chilene, gebürtig aus Chillan, einer Stadt in Süd-Chile, lebte während 20 Jahren in argentinischem Gebiet, wo er die ersten Symptome seiner Krankheit merkte. — Dieses war ein Fall von „Lepra tuberosa“; doch hat die Regierung hinsichtlich desselben keine Vorkehrungen getroffen.

Diese zwei Fälle, sowie der erwähnte in Valparaiso sind die einzigen, die man in Chile studiert hat und von denen man überhaupt Kenntnis besitzt.

Titel der Veröffentlichungen in Chile in Bezug auf die Lepra, welche bei dieser Arbeit zu Rate gezogen sind:

1. Information über einen Leprafall, welche der „Consejo Superior de Hijiene Publica“ bei Dr. Louis Frömel eingezogen hat (archivo de sesiones del Consejo Superior de Hijiene Publica, tomo IV. año 1895, p. 37).

2. Bericht des Dr. Frömel an den „Consejo Superior de Hijiene Publica“ über Lepra (archivo de sesiones del Consejo de Hijiene Publica. tomo IV. año 1895. p. 69).

3. Ausgabe des Ministeriums des Aeusseren an den „Consejo Superior de Hijiene“, in welchem die Untersuchung der für Chile von Europa geworbenen Ein-

Kranke war ein Portugiese von den Kap Verdischen Inseln. Man hatte es hier mit einem Fall von „Lepra tuberosa“ zu tun, und die mikroskopische Untersuchung bestätigte die Diagnose.

Der „Consejo de Hyienc Publica“ in Santiago beorderte die Isolierung des Kranken oder die Verweisung aus dem Lande; nach Abkommen der Lepra-Konferenz in Berlin im Jahre 1897.

Hiergegen widersetzte sich der Kranke; und da hinsichtlich der Lepra keine Gesetze bestehen, so blieb der Kranke aus freien Stücken in einem Hospital in Valparaiso, wo er in einem allgemeinen Saal untergebracht ist und nur seine aparte Bedienung hat.

Aus dem Vorhergehenden ersieht man, dass die Lepra in Chile keine Ausdehnung gewonnen hat, und da seit dem erwähnten Fall in Valparaiso, welcher seit dem Jahre 1898 dort isoliert ist, kein anderer aufgetreten ist, so kann man mit Sicherheit daraus schliessen, dass die Lepra in Chile nicht heimisch, sondern entweder importiert ist, oder sich bei Personen entwickelt hat, welche häufigen Umgang mit Individuen gehabt haben, welche die Lepra von auswärts eingeschleppt haben, aus Ländern, in denen sie heimisch ist.

Die Regierung lässt die von Europa für Chile geworbenen Einwanderer von einem Arzt dortselbst untersuchen; ferner ist es jedem Arzt geboten, den Autoritäten unverzüglich Bericht zu erstatten, falls in seiner Praxis ein Leprafall vorkommen sollte.

Ich habe Bedenken gehabt, überhaupt über dieses Thema zu schreiben; und halte ich diese Arbeit nur insofern von Wert, da sie Aufschluss über die in Bezug auf Lepra bei uns herrschenden Verhältnisse gibt.

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wanderer vor ihrer Abreise dortselbst angeordnet ist (archivo de sesiones del Consejo Superior de Hijiene Publica. tomo IV. año 1895. p. 106).

4. Bericht des „Consejo Departemental de Hijiene“ in Valparaiso an den „Consejo Superior de Hijiene Publica“ über einen Leprafall in Valparaiso (archivo de sesiones del Consejo Superior de Hijiene. tomo VII. año 1898. p. 135.

5. Beschluss des „Consejo Superior de Hijiene Publica“ einen Bericht über diesen Fall an das Ministerium des Innern zu senden (archivo de sesiones del Consejo Superior de Hijiene. tomo VII. año 1898. p. 146).

6. Anweisung des „Consejo Superior de Hijiene Publica“ für den „Consejo Departemental de Hijiene“ über die zu treffenden prophylaktischen Vorkehrungen bei Leprafällen (archivo de sesiones del Consejo Superior de Hijiene Publica. tomo VII. año 1898. p. 148).

7. „La Lepra i su profilaxis“ von Dr. Pedro Peña, Vertreter der Regierung von Paraguay auf dem ersten latein-amerikanischen medizinischen Kongress in Chile im Jahre 1900.

7. Mitteilungen des Dr. Roberto Montt Saavedra über einen Leprafall in Valparaiso auf dem ersten latein-amerikanischen medizinischen Kongress im Jahre 1900.

Egypten.

Bericht

von

Franz Engel-Bey in Cairo.

1. Statistik:
   a) Seit der offiziellen Zählung der Leprösen in Egypten im Jahre 1890 liegen neue Nachforschungen über die Zahl derselben hier nicht vor.

   Nach einer persönlichen Beurteilung der Sachlage ist jedoch eine weitere Verbreitung derselben nicht erfolgt und nicht zu befürchten.

   b) Asyle, Kolonien etc. sind bisher nicht eingerichtet.
2. Massregeln zur Bekämpfung der Lepra sind hierselbst bisher nicht ergriffen worden, die Bewegung der Leprösen ist hier wie früher völlig unbehindert.

Ausser durch die stets vorhandenen hie und da zu kleineren Epidemieen anschwellenden Pocken, Flecktyphus und anderen schweren Infektionskrankheiten ist Egypten im letzten Jahrzehnt zweimal und schwer von der Cholera, seit einigen Jahren von der Pest, neuerdings auch von der Rinderpest heimgesucht. Diese Seuchen, welche die Wohlfahrt des Landes auf das Schwerste bedrohen, haben die Aufmerksamkeit und Arbeitskräfte der Sanitätsverwaltung des Landes so völlig in Anspruch genommen, dass es derselben tatsächlich unmöglich war, sich mit der Leprafrage zu beschäftigen.

Wenn es aber auch zu beklagen ist, dass die systematische Bekämpfung der Lepra bis jetzt nicht in Angriff genommen werden konnte, so muss ich doch darauf hinweisen, dass diese im ganzen Orient und in Egypten seit den ältesten Zeiten einheimische — hier, so viel wir wissen, niemals bekämpfte Seuche, in Egypten, wohl schon seit alten Zeiten — so wenig infektiös auftritt, dass sie hier nie eine grössere Verbreitung erlangt hat. Es ist deshalb, wie ich dies in meinem Vortrag auf dem 1. Egypt. medizin. Kongress, Dez. 1902 darlegte (von dem ich mir ein Exemplar beizufügen gestatte), von einer Leprågefahr in Egypten auch heute nicht die Rede.

Die Lepra muss demnach den andern brennenden Fragen der vehementesten Infektionskrankheiten, wie Cholera, Pest gegenüber in ihrer Bedeutung als Volksseuche naturgemäss in Egypten zurücktreten

und ihre Bekämpfung muss, so bedauerlich es ist und kann — glücklicherweise — auf eine günstigere Epoche verschoben werden.

In my first report[1]) on Leprosy in Egypt, for which the Board of Health made an official inquiry in 1890, I called attention to the fact that this disease was believed to have existed amongst the early ancient Egyptians, even before their appearance in history.

For this statement I relied on Brugsch and his reading of the Berlin Papyrus, from which it appeared that a treatise on leprosy had been found dating from a very early period, as early, that is to say, as the Fifth Pharaoh. This document, which, according to Brugsch, consists of a collection of all sorts of remedies against this malignant disease, was found in a box of manuscripts which lay under the feet of the Divine Anubis in the town of Sothem But my learned friends, the Egyptologists, have since assured me that the translation of these hieroglyphics is not at all reliable, as no particulars have been anywhere found describing the symptoms of this disease.[2])

I was therefore surprised to find that Dr. Sauton remarks in his work „La Léprose" that „on a découvert des sculptures reproduisant les mutilations lépreuses, et ces sculptures remontent aux premières dynasties des Pharaons". And, that, in answer to a critical review by Dr. Glück[3]) he says[4]); „Quant aux mutilations lépreuses, gravées sur la pierre et remontant aux premières dynasties de Pharaons, elles sont conservées au Musée du Caire, avec les indications archéologiques qui en expliquent la nature et l'origine". It is a pity that Dr. Sauton forgot to give more precise details about these monuments and his authorities for his statements.

Not only have my inquiries been in vain, but my friends, the Egyptologists, Dr. von Bissing, Borchard, Rubensohn and others, as well as M. Maspero, appear to know nothing whatever of the existence of such monuments in the Egyptian Museum at Cairo or elsewhere.

Consequently the statement that Leprosy was brought from Egypt by the Jews is also unfounded, although it has often been repeated.

Moreover it is uncertain whether the word „Zaraath" mentioned in the Bible refers to leprosy or not, in spite of the statement of Dr. Tenneson, quoted by Dr. Sauton[5]). Professor Münch, who has studied the question thoroughly was of the firm opinion that „Zaraath" did not refer to leprosy at all. Thus any real proof of the existence of the disease in early Egyptian history is still wanting.

On the other hand it is now almost certain that the word Phoenician disease, leuke, which Herodotus uses and his statement about the preventive measures to be taken against this disease refer indeed

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1) Published in the „Monatshefte für praktische Dermatologie", edit. by Dr. Unna, 1893.

2) See, Verhandl. der Leprakonferenz. Berlin 1897. I. p. 138. Fr. Engel: Notizen über die Lepra in Egypten.

3) Lepra, Vol. 2, Fasc. 4. p. 238.

4) Lepra, Vol. 3, Fasc. 1. p. 45.

5) L. c.

to leprosy. For his emulator Ktesias mentioning the same measures uses the word „Pisagas" which as we learn from the recent publication of Bloch[1]), still means the real leprosy in modern Persian. But it is still doubtful, according to Hirsch[2]), whether these notes and those of Rufus really refer to Egypt or Greece.

Nevertheless, it is certain that Leprosy existed in Egypt long before the Christian Era and that it spread to the Roman Empire during the first century before Christ; but at the same time it seems to have been almost unknown in Italy in the days of Celsus[2]).

We have been accustomed to consider Egypt as the Cradle of Leprosy, and to regard Egypt and Syria as the main points from which the spread of this disease in the Occidental countries commenced. But its transmission by the crusades to the Western countries was refuted long ago by Virchow and others, who pointed out tha leprosy asylums already existed during the VIIth century in Switzerland, at Metz, Verdun and other places.

Boinet stated quite recently that it is noted in the annals of Aix, and that according to a decree of a council held in the year 529 at Orleans, the bishops were already instructed to watch the lepers[3]).

If we consider how difficult it is even at the present time to detect sporadic cases of leprosy and their slow dissemination, we may admit that the disease existed in the Western countries long before it obtained that hold which necessitated the segretation of lepers. And therefore it seems to be altogether questionable whether leprosy was brought by the Romans from Egypt and Syria to the West. Indeed, it may have travelled with the Indo-Germanic races from their original countries in the far East; it is known that the history of leprosy in those countries extends back certainly to the VIIth and in India perhaps even to the XVth century before Christ, some notes about it having been found in the Zendavesta and the Rig-Veda. The word „leprosy" itself, according to Bloch, is of Indo-German origin which signified a contagious disease of the skin of a somewhat indefinite nature.

Apart from all this, it is a fact that leprosy has remained endemic in Egypt for some thousands of years, though the people of the western countries rid themselves of the disease by the severe compulsory segregation of lepers, several centuries ago.

Since the middle of last century and more particularly during the last 10 years, smaller and greater centres of leprosy have been discovered on the frontiers and border countries of Europe, especially in the North, South-East and South-West (a fact which has more and more attracted the serious attention of the physicans and governments of all civilized countries so that an International Congress to which I had the honour of being invited was held at Berlin in 1897 to discuss the question of Leprosy).

But leprosy has neither disappeared from Egypt nor from the East,

1) Lepra, Vol. 2, Fasc. 3. p. 178.
2) Hirsch, Handbuch der Histor. Geogr. Pathologie. 2. Bearbeitung. II. S. 4.
3) Lepra, Vol. 2, Fasc. 4. p. 223.

Macrizi[1]) reports that in the year 707 Ben Abdelmalek ordered that lepers should be segregated in an asylum which the generous Sultan first erected; but this order only applied to Cairo, and the asylum disappeared some time afterwards. Macrizi further says that when Mohamed Ebn Touloun constructed another hopital about 200 years later, there were no hospitals in Cairo, and the latter also disappeared. He then mentions the foundation of several other hospitals which were erected by successive Sultans up to the XVth century, but he never speaks again of any laws relating to lepers nor even of the word leprosy. Prosper Alpinus says in his Medecina Aegyptorum[2]) speaking about Cairo that „lepers are often seen amongst the poor".

Dr. Larrey[3]) writing about 1800 relates that lepers in Cairo used to keep themselves isolated from the rest of the people, but he does not mention any preventive measures against them, whilst Pruner in 1847 says that quite unlike those of other oriental countries, the lepers of Egypt were permitted to go about quite freely among the people[4]).

Thus if we have to regard it as a fact that leprosy in Egypt was never dealt with nor any attempt made to check it, but that it was freely allowed to develope, we are astonished that the number of lepers found in Egypt is proportionally so small.

The former Conseil de Santé estimated, after an inquiry in 1882, their number to be 1018; in 1889, when an enumeration of lepers was suggested by H. R. H. then the prince of Wales (now H. W. King Edward VII), and whilst we were already preparing the general inquiry, 1425 cases were reported. Finally our inquiry which had been carefully prepared gave a total number of 2204. But still this figure must be considered smaller than might be expected, for in Alexandria and Cairo, for instance, only a very few cases were repored and we are also sure that the number given in some provinces as Ghizeh, Minieh and Fayoum, was too small to be correct. The total number of women appearing in the lists is 20 % of all cases, which is certainly an underestimate; and further we may believe that many cases which were still in the early stages of the diseases escaped detection. Yet, even if we admit that the last number notified was too small by some hundreds or might even be almost doubled, the number of lepers in Egypt is still proportionally small. In Portugal in the year 1821[5]), the number of lepers was reported to be about 800 (another estimate brings the figure even up to 3000); in Sicily 114 were notified about the years 1875[6]); whilst the number of lepers in Crete was recently estimated by Ehlers and Cahnheim[7]) at 600 amongst a population

1) Macrizi, Hospitals. Vol. 2. p. 405.
2) Prosper Alpinus, De Medicina Aegyptorum. Venetiis 1591. p. 25.
3) Description de l'Egypte. Etat Moderne I, p. 492, Dr. Baron de Larrey, La lèpre.
4) Die Krankheiten des Orients. Dr. F. Pruner, 1847, p. 173.
5) Hirsch, l. c. S. 14, 15.
6) Lepra, Vol. 2, Fasc. I, 2. p. 76.
7) Lepra, Vol. 2, Fasc. 3. p. 160.

of about 300 000 i. e. two per thousand. Judging by this, we might expect 18 000 lepers in Egypt. And it must be remembered that in all these countries segregation of lepres was compulsory, leprosy being considered a contagious disease, and only very few doctors are still doubtful as to the truth of this contagiousness. We have now the striking fact that leprosy spread to a very small extent in Egypt, in spite of the fact that lepers were not isolated and were allowed to move about quite freely amongst the people, and could even engage in all sorts of trades, which undoubtedly caused great danger of infection.

In fact, if we adopt the latest ideas on the subject, which show that secretions from open wounds, and from the nose and throat (the latter being disseminated through the surrounding atmosphere by talking, sneezing or by coughing [fingers!]) are a constant cause of the spread of leprosy, our recent inquiry, as well as my personal experience, proves that danger exists in a large measure in Egypt.

We found that lepers engaged in all sorts of trades and were even teachers, sheikhs, vegetable and sweetmeat dealers and fishmongers, cigarette, water and milk sellers; and this we found in the most frequented places. If, at first, it appears incomprehensible that this disease has not spread more in Egypt by such means, we have only to remember the well known fact that even in a more intimate way of living as happens between a husband, wife, and children, the transmission of the disease from one to another rarely happens.

As leprosy is in many ways similar to tuberculosis, we may compare these diseases on this point. It is well known that the transmission of the latter disease from one person to another, even amongst married people, is but seldom observed. But still tuberculosis can be transmitted much more easily than leprosy. We have not yet succeded in cultivating the leprosy bacillus in any medium, or in transmitting it esperimentally to animals in order to reproduce leprosy in them. Up to the present time we know only that human beings are the only sufferers from, and carriers of, the disease; whereas the babacillus of tuberculosis can easily be cultivated and is virulent in the case of animals; it even exists though in a slightly different form in animals.

If we admit then that the transmission of leprosy is very rare, we must, nevertheless, be very careful in our conclusions; for we know that leprosy is an extremely lingering disease, that in early times leprosy was very common, even in Western countries and that at the present time it spreads more rapidly among people who have not formerly been in contact with leprosy.

In the Sandwich Islands, the origin of the disease is not sufficiently explained and its supposed importation by the Chinese[1]) is not proved. It is, however, certain that about the middle of this century, it was still so little known there that it did not attract general

1) According to the well known statement of Dr. Hillebrand, about the year 1848; but Rev. Ch. S. Stewart considers leprosy as a frequent disease already in 1823. See: Hawaii Official Government Report 1886.

attention; and yet from 1866 to 1876 nearly 2000 lepers had to be segregated.

In South Africa, we learn from Hutchison[1]) that according to Dr. Cassilis, leprosy was imported amongst the Basutos by the Hottentots, and was in recent years still limited to foreigners. But now 250 lepers exist amongst them and the disease is apparently spreading.

As in the case of other infectious diseases, leprosy may be fought or stopped by systematic measures, or in voluntarily way by the cleanliness of a population, keeping pace with the progress of civilisation. But for Egypt we must admit that other reasons existed which acted against the spread of the disease. It is possible that lepers are less resistant to other infectious diseases and are therefore carried off in greater numbers by small-pox, dysentery, typhus, plague, and suchlike. On the other hand, a great number of children die between the ages of 2 and 5 years. Therefore a population more resistant to leprosy may survive; for we admit in the case of tuberculosis that some people and families are more susceptible, and others again more or less immune against it. But that would not sufficiently explain why leprosy should have developed less in Egypt than it did in the Occidental countries. We are, therefore, driven to te conclusion that leprosy has in this country less tendency to spread than in other countries, and I believe it to be in accordance with facts, when I express the opinion that it is the climate of Egypt which is the chief influence at work in this connexion. It seems, indeed that in colder countries, or more accurately in countries in which there are besides the greater cold, a higher degree of moisture of the air and less sunshine, leprosy shows greater powers of development and appears at the same time in more acute and severe forms.

It is interesting from this point of view to compare the proportion of the nodular and nervous forms, of which the latter is considered more benign, in Scandinavia, Crete and Egypt.

In Norway from 1850 to 1890 7308 lepers were notified, 5049 of which were of the nodular and 2259 of the anaesthetic form, that is to say, a proportion of about 2:1. Ehlers[2]) found in Crete 153 nodular against 138 anaestethic lepers, that is about 1,1 to 1.

In the enquiry we made in Egyt in 1890, out of 848 cases, of which sufficient details were given — 247 were of the nodular and 220 of the anaesthetic form, id est 0,6:1; 332 were mixed cases (34 of mutilating leprosy) besides 17 macular cases. Macular cases have been included in Ehlers's figures with the anaesthetic.

Thus, we learn that in Egypt the anaesthetic form seems to prevail, and to be proportionally much more common than in Norway and even in Crete. We must not be misled by seeing more nodular cases for the anaesthetic lepers are much less conspicuous and offensive, and are therefore very often overlooked. This is so true that Pruner

1) Lepra, Vol. 2, Fasc. 1. p. 4.
2) L. c.

and former writers do not mention nervous leprosy and Pruner speaks only of the nodular and the mutilating forms (Gelenklepra).

Another reason for our opinion that leprosy is in Egypt generally of a milder and more chronic character, is that whilst, for example in Hawaii in 1868 (when the seclusion was not so rigorously enforced and fresh cases would not have been detected to any great extent) there were amongst the well known cases 64 % of three years duration or less, in Egypt we found only 25 % of lass than five years duration. Also the mortality of lepers was much higher at Molokai than that found by us in Egypt in the course of an additional enquiry.

If however, we admit that leprosy in Egypt is really milder and has no remarkable tendency to spread amongst Egyptians, we have further to consider the question whether foreigners run here a notable danger of contracting the disease, especially as during the last 10 to 20 years, several cases of such infection of Europeans in Transatlantic Countries have been reported and foreigners are constantly coming and settling here in large numbers

Regarding this question, I am glad to state that according to my knowledge and the special enquiry on this point no foreigners have ever been infected here with leprosy. In addition to the natives, there are, it is true, some Greek lepers known and amongst my photographs of lepers we find two Greeks whom I saw at Alexandria, but they came from the infected Grecianislands and certainly did not contract the disease here. As far as I know in recent times nobody even pretended that any individual from a country which is free from lepers contracted the disease here.

The only cases of Europeans which are cited by Pruner and others, said to have contracted it in Egypt, are those which are reported by Baron de Larrey[1], the distinguished surgeon of the French expedition in the beginning of the last century. But in reading the details which Dr. Larrey gives about these cases[2] (there are only two) we are firmly convinced that, notwithstanding the fact that he has seen lepers in Egypt, the cases he mentions had nothing whatever to do with leprosy.

As the remarks about leprosy infection amongst the French troops in Egypt are reported in various historical notes on the subject of leprosy, allow me here to refer the reader to the original publication of the scientific Commission, as it would be too long to reproduce Dr. Larrey's report in full. (The notes on leprosy by Macrizi, Prosper Alpinus and Pruner are also of interest.)

We must conclude therefore that leprosy is very slightly contagious here either for foreigners or natives (we should add that we found very few cases amongst the Bedouins) and that the risk of contracting the disease in Egypt does not really exist for foreigners or at any rate is not greater than in Spain, Portugal, the Riviera, Sicily, and is certainly less than in Greece. The danger is here in fact probably less in the case of leprosy and in that of other infectious diseases, because the

1) L. c.
2) L. c. p. 493 and 497.

Europeans, even of the lower classes do not associate with the natives as they do frequently in the abovementioned countries.

Now we come to the final question, whether we shall let things go on as they have been going for some thousand years, or wheter in accordance with the progress of science and civilisation, we shall begin in Egypt to fight against leprosy as the sanitary service has done during the last ten years so succesfully against other and more acutely infectious diseases, such as cholera and plague.

With regard to this we have to observe that however slightly contagious leprosy may be in Egypt, admitting that the disease cannot be spread in any other way but by leprous individuals, leprosy will continuet o be endemic in Egypt in the future as it has in the past if nothing is done in the way of the segregation of lepers.

The good results of the seclusion of lepers are no longer disputed. It is proved not only by the history of former times, but also by that of our own. Only 85 lepers were found and sent from Hawaii to Molokai in 1900, whereas in the years 1888 and 1889, about 400 were sent there each year when inspection was much less strict.

In 1850, 2871 lepers existed in Norway, which number decreased rapidly after the introduction of the mild preventive measures proposed by Hansen, and was reduced in 1897 to 700.

Hansen calculated that in about the year 1920, no cases of leprosy would be found in Norway[1]). Already in 1895, 3 leproseries could have been dispensed with and transformed into sanatoria for phthisis.

As the Board of Health has, under the englightened Government of His Highness, undertaken with great succes the work of systematically combating the acute infectious diseases, which in former times decimated the population and ruined the country, there is no doubt that as soon as there is an opportunity to begin the struggle against the chronic infectious diseases, the necessary steps against leprosy will be taken in accordance with the special conditions of the climate and the country.

In an article published in the Mitteilungen der Lepra-Konferenz, Berlin 1897, p. 133, I stated my general ideas how leprosy should be fought, taking into consideration the necessity of isolating lepers in accordance with our modern views of humanity, and this was the reason why I recommended especially for Egypt the creation of agricultural leprosy colonies.

But, whatever be the plan the Sanitary Board may recommend to deal with leprosy, the time is approaching, when, as Pruner (l. c.) wrote about 50 years ago: „It may be hoped that this horrible disease will disappear from Egypt, when the Oriental peoples can enjoy the blessings of good hygiene under the protection of a better constituted Government".

1) Mitteilungen der Lepra-Konferenz Berlin 1897, Vol. 2, p. 164.

England.

Bericht

von

George Pernet in London.

In response to the request contained in a letter addressed to me by Professor Lesser, of Berlin, President of the Fifth International Congress of Dermatology, and Dr. O. Rosenthal, the General-Secretary, to report on Leprosy in the British Empire and the means taken to deal with the disease since the International Leprosy Conference held in Berlin in 1897, I took steps immediately to obtain information on the subject. I may say that the present enquiry has been suggested by the Prussian Government, at whose instigation also the aforesaid Leprosy Conference was held.

In the original letter received from the General Secretary, South Africa was the only part of the world excluded from the Survey entrusted to me, but I discovered subsequently that Mr. Wellesley C. Bailey, Secretary of the Mission to Lepers in India and the East, and Dr. J. Ashburton Thompson of Sydney, had been asked to report on British India and Australasia respectively. This only came to my knowledge after I had sent a circular letter asking for data to a number of officials in India and Burma. In answer to my request in this direction, I have received a number of valuable reports on which I shall briefly touch in this paper, notwithstanding Mr. Bailey's excellent general statistical survey, with a private copy of which he has been kind enough to furnish me. I cannot do otherwise seeing that a number of gentlemen in India and Burma have been put to trouble and inconvenience in the matter, owing to the oversight in the instructions from Berlin which I have alluded to.

As to Australasia, Dr. Ashburton Thompson, who has made a special study of Leprosy in that part of the world, will supply a separate report. I take this opportunity, however, of thanking correspondents in Australia and Tasmania who have been good enough to supply me with information in reply to my circular letter to them. After I had got out my circular letter, I was asked by the General Secretary of the Congress to supply data on the lines suggested by Professor von Petersen of St. Petersburg so as to secure uniformity

in the returns. By the courtesy of the Editors of „The British Medical Journal“ and „The Lancet“, these details as to the scope of the enquiry were notified in the columns of these two journals.

This being said by way of introduction, I will now proceed to review the materials I have collected. At the request of Professor Neisser of Breslau, who is dealing with the subject as a whole, I am obliged to do this briefly, but I may say the valuable information so kindly placed at my disposal will be carefully preserved and made use of in a way advantageous to the elucidation of the Leprosy problem.

Europe.

Great Britain and Ireland.

I have communicated with all the medical men likely to have cases of leprosy under their care. I have received replies from the majority of these. The number of lepers in this country at the present time can only be approximately ascertained. Taking every care not to count any case twice over, as far as I have been informed, and including cases which come under my own observation, there are some twenty-three lepers under observation in Great Britain and Ireland, eighteen males and five females. Some of these cases are not always in this country, but come and go. The disease in these patients has been contracted in various parts of the world: Australia, West Indies, South Africa, British Guiana, Singapore, India, Burma and other places where leprosy is endemic. That there are other cases in the British Isles, either overlooked or not reported to me is undoubted, but allowing for this, the total number of lepers is not likely to be more than 40, or at most 50 at the very outside. This is of course a rough estimate. Instances of leprosy are much less likely to escape observation now than used to be the case.

In 1899, an instance of leprosy said to have been contracted in England (a male), was reported (1). This case has unfortunately been lost sight of, so my endeavours to see the patient personally have failed.

Since the Berlin Leprosy Conference was held several cases of leprosy brought before Societies have been reported (2), but some of these were old ones, which were referred to in 1897.

Since 1897 again, three cases to my knowledge have died, viz.: an English sailor, who committed suicide; a lad from British Guiana, who died suddenly; and a Jewess from Mitau, who had developed the disease after arrival in this country (3).

I have also made enquiries with regard to another male case, which came under my notice, a native of Bombay, who was when last seen by me in an advanced stage of the disease, but they have been unsuccessful. This patient may have died. I have also made enquiries in various other likely directions for information, but there is little to add to what I have said. In the foregoing remarks I have avoided giving details which might lead to the identification of living cases, and thus add to the sufferings and difficulties of the unfortunate patients and their friends.

In this country, leprosy is not among the notifiable diseases, any more than is that other contagious disease, tuberculosis pulmonum. Patients suffering from the disease are free to go about as they like. Hospital cases are not isolated, but admitted to the general wards.

As to England and Wales, Dr. John Tatham of the General Register Officer, Somerset House, has kindly informed me that three deaths were raturned as from leprosy in 1902, and one in 1901. No death from this cause was returned during 1903. I may add that leprosy is not mentioned in the official list of causes of death.

With regard to Scotland and Ireland, the Registrars General have informed me that no death has been reported as due to leprosy during the period 1897 to date.

There was no leprosy in the British Navy during the period 1897 to date.

As to the British Army, I am indebted to the Secretary of the Army Council, War Office, for the information that during the period 1896—1903, two cases only were recorded, both of the anaesthetic type and both occurring in India. The two patients were discharged or invalided in 1900 and 1902 respectively.

Dr. Herbert Brown, Resident Medical Officer, London School of Tropical Medicine, kindly informs me that three cases have been under observation there since 1897, two of which have died, viz.: a Norwegian and a Dane.

Although the disease is undoubtedly contagious, it requires special conditions to favour its diffusion. The experience of this country, with the exception of the well-known Irish case, and perhaps the case reported by Dr. MacMahon, is that the disease does not spread. But the possibility of such an occurrence, where there is overcrowding, uncleanliness, and so forth, cannot well be excluded, especially in view of the wholesale immigration into this country of individuals from infected areas in Russia and Roumania. This possibility I have pointed out elsewhere (4).

Gibraltar.

Colonel J. McNamara, Principal Medical Officer, informs me that Major W. H. Horrocks, R. A. M. C., has only been able to find the records of one case of Leprosy, which dates back to 1890. The patient was a Maltese, who had been to Spain, France and North Africa. It is suggested the man was infected in the last named, but I may point out that leprosy occurs in Malta. One of the worst cases of leprosy I saw in the Mustapha Hospital, Algiers, was in a Maltese. There are also leprous foci in Spain.

Malta.

I have not received any information from this colony in reply to my circular letter, but Mr. Secretary Lyttelton, of the Colonial Office, has kindly furnished me with a copy of the Ordinance No. VII of 1893 (in Italian and English), which was enacted for checking the spread of leprosy. Any case coming under observation must be reported. The report is then submitted to a Medical Board composed of five physicians, of whom only three are in the Service of the Government. It rests

with this board to confirm the diagnosis, and in that case to have the sufferer removed to an Asylum for lepers in the Island, to be detainied there during the duration of the disease. There are penalties for those who assist in concealing the disease or try to prevent removal of the patient to the Asylum. Any inmate of the Asylum may leave the island for the purpose of fixing his residence abroad.

Cyprus.

I am also indebted to Mr. Secretary Lyttelton for a copy of the Report for 1902—1903 from which I take the following details concerning the Leper Asylum. Twelve were admitted as inmates at the leper asylum, and 9 deaths occurred during the year. There were 106 inmates on the 31st March, 1903. Isolation from the general public is maintained so far as is practicable. The establishment is a satisfactory one, and the patients, who are housed in neat cottages on a chiftlik or farm, appear to be more contented with their accommodation than is sometimes the case in leper institutions. Each patient is allowed 300 drams of bread and $2\frac{1}{2}$ c. p. a day to buy food, and lays out his allowance as he desires through an agent or servant of the institution. The system works well, and the little excitement of choosing and settling the food appears to lessen the dreadful monotony felt in leper asylums where the patients have a stereotyped diet week after week, or year after year, while awaiting their death.

Provision has been made for the children born in the asylum of poor parents who are lepers, and who are unable to support them. Special care is taken of these children who have been rescued from the dreadful risks of contracting the disease, and who may thus be saved for useful lives.

The law regulating the segregation and treatment of lepers dates from 1891 (Lepers' Law, Cyprus, No. IV, 1891). Suspected cases of leprosy must be reported, and there are penalties for wilfully neglecting this. The case is then carefully gone into. No person can be detained in a Leper Asylum unless certified as such by two medical men, one of whom must be the Chief Medical Officer of the Island.

Asia.

British India and Indian Ocean.

With reference to India, I may premise my remarks by stating that since the Berlin Conference of 1897, an Act (Act No. 111 of 1898) has been passed in India providing for the segregation and medical treatment of pauper lepers and the control of lepers following certain callings. The details of this Act, as also those of the Bengal Act No. V. of 1895, have been published by me in extenso in „Lepra“ by the courtesy and with the sanction of the late Secretary of State for India, Lord George Hamilton, in Council (5). It will be found at the end of this report (See Appendix I.)

Moreover in 1903, an Act further to amend the above Lepers Act (1898) received the assent of the Governor-General of India in Council.

It provides for the segregation and medical treatment in British India of lepers belonging to Native States (See Appendix II).

I am indebted to Major J. T. W. Leslie, M. B., Secretary to the Sanitary Commissioner with the Government of India for, among many other details, a useful list of references, which will be found in the bibliography at the end of this report (6).

Mr. Wellesley C. Bailey, in his report, has dealt fully with the statistics and various other matters relating to the subject. In the following pages I will touch on some points which are germane to the present enquiry. I will take the Presidencies, Provinces, Native States &c. in alphabetical order for the sake of ready reference.

Ajmer-Merwara.

Lepers Act not in force, but advisability of extending it to this area now under consideration. No asylums. No regulations.

Assam.

The Lepers Act, 1898, extended to Assam (1902). Leper Asylum at Sylhet (instituted 1902).

Colonel David Wilkie, I. M. S., Acting Principal Medical Officer and Sanitary Commissioner, has kindly forwarded me a statement compiled from the reports furnished by the District Civil Surgeons.

Name of district	No. of lepers according to the census of 1901			Number of lepers treated in the dispensaries									
	Males	Females	Total	1894	1895	1896	1897	1898	1899	1900	1901	1902	1903
Cachar	268	102	370	No information furnished									
Sylhet	1728	422	2150	See Civil Surgeon's report									
Goalpara	510	139	649	13	15	12	13	10	13	11	22	19	43
Kamrup	400	83	483	No information furnished									
Darrang	135	47	182	No information furnished									
Nowgong	102	34	136	—	—	—	—	—	30	38	45	19	28
Sibsagar	407	143	550	No information furnished									
Lakhimpur	203	84	287	See Civil Surgeon's letter									
Naga Hills	18	9	27	—	—	—	—	—	—	1	3	4	3
Garo Hills	65	37	102	See Dr. Crozier's note									
Khasi Hills	54	35	89	No information available									
Lushai Hills	5	1	6	—	—	—	Not received				—	—	—
Manipur	43	14	57	—	—	—	0	1	0	1	0	7	1
Total	3938	1150	5088	13	15	12	13	11	43	51	70	49	75

Baluchistan.

There are no Leper asylums, and occasion has not arisen for adopting provisions of Lepers Act. According to Mr. C. E. Yate, Agent to the Governor-General and Chief Commissoner, leprosy is practically unknown. The only cases that have been under treatment during the last year or two all came from Afghanistan, but there are only 4 or 5 in number.

Baroda (Native State).

There is only one Leper asylum maintained by the State, situated on the bank of Narbada near Ausaya. Number of inmates, 72. Object is to afford shelter. Mission bodies do not maintain any, and none erected since 1897. No provisions of Lepers Act, 1898, have been adopted, nor regulations regarding the treatment of lepers brought into force since 1897.

Bengal.

I am indebted to Mr. L. P. Shirres for the details of Asylums as under:

Site or name of Asylum	Date of erection	By whom maintained	Number of Lepers			
			Adult males	Adult females	Children	Total
Lohardaga	1884	Mission to Lepers in India and the East	27	1	—	28
Purulia	1889	Ditto	277	218	98	593
Raniganj	1893	Ditto	91	38	13	142
Asansol	1891	Ditto	40	30	9	79
Bhagalpur	1891	Ditto	75	21	9	105
Bankura	1902	Ditto	43	13	14	70
Muzaffarpur	—	German Lutheran Mission	—	—	—	20
Deoghur Rajkumari Leper Asylum	1895	From private charity	23	3	1	27
Albert Victor Asylum for lepers at Gobra	1811	By Government	73	25	—	98

The Provisions of the Lepers Act III of 1898 have, by notification of the Bengal Government, been applied to the whole of the territories under the administration of the Government of Bengal. The Albert Victor Asylum at Gobra (Calcutta) and a portion of the asylum at Purulia (Mission to lepers in India and the East) have been declared leper asylums for the purposes of the Act.

Bombay Presidency.

The following is a complete list of Leper Asylums in the Bombay Presidency, together with information showing (a) the number of inmates and special objects and characteristics of each asylum, (b) which of them are maintained by Mission bodies, and (c) which of them have been erected since 1897.

The Lepers Act III of 1898 has not been applied to any part of the Bombay Presidency, and no regulations have been framed regarding the treatment of lepers. None of the Municipalities in this Presidency have adopted any measures towards the suppression of leprosy, though some of them contribute towards the maintenance of Leper Asylums.

List of Leper Asylums in existence in the Bombay presidency.

Name of the town in which a Leper Asylum is located	Number of Asylums	Number of Inmates	Special objects or characteristics of Asylums	Remarks	
Native States.					
Baroda	1	79	To alleviate suffering and to prevent lepers from mixing with healthy people.	—	
Savantvadi	1	58	To accommodate lepers who are natives of the State and who have no means of subsistence.	—	Erected before 1897.
Dharampur	1	42	To arrest the progress of leprosy by providing segregation and treatment.	Maintained by the State.	
Kathiawar.					
Junagad (Prince Victor Leper Asylum)	1	69	—	—	
British Territory.					
Trombay, Thana District (Edalji Framjee Albless Leper Asylum)	1	22	—	Maintained by the Catholic Mission.	
Matunga Asylum, Bombay	1	360	—	Maintained by the Bombay Municipality Government contribute Rs. 18000 per annum.	Erected before 1897.
Ratnagiri (Sir Dinshaw Manakji Petit Leper Asylum	1	97	Lepers from the Ratnagiri Districts are admitted free. Lepers from other Districts are admitted on payment of Rs. 99 per annum as per Government Resolution No. 3380 of 20th August 1889, General Department.	Maintained by Government contribution and other donations and subscriptions.	Erected before 1897.
Poona	1	42	To accommodate lepers who are unable to work and who are poor and helpless.	—	
Sholapur	1	68	—	Maintained by the „Mission to Lepers in India and the East" Annual grant of Rs. 2000 is made by Government.	Erected since 1897.
Nasik	1	70	—	Maintained by the „Mission to Lepers in India and the East".	

Name of the town in which a Leper Asylum is located	Number of Asylums	Number of Inmates	Special objects or charakteristics of Asylums	Remarks	
Belgaum	2	28	To give charitable assistance to poor lepers who are abandoned by their relatives.	The Asylums are under the care of Roman Catholic Chaplains of the two Asylums, one is for males with 15 inmates, and the other for females with 13 inmates.	Erected before 1897.
Pen, Kolaba District	1	61	The object is charity coupled with the desire of freeing the public from annoyance.	Established by the American Mission.	
Poladpur, Kolaba District	1	75			
Ahmedabad	1	55	—	—	
Magar Pir (Pir Mangho) near Karachi (Sind)	1	19	There are a number of hot springs, from bathing in which it is believed patients find relief.	Maintained from public subscriptions and donations and a Government contribution.	

Burma.

There are 4 leper asylums:

Asylum	Total number of lepers treated during the year				Daily Average			
	Men	Women	Children	Total	Men	Women	Children	Total
Rangoon Leper Asylum (1903)	107	20	5	132	62	15	5	82
St. John's Leper Asylum Mandalay (1903)	267	94	21	382	189	74	1	264
Wesleyan M. Home for Lepers Mandalay (1902)	105	31	16	152	Data not available		—	—
Moulmein Leper Asylum (1903)	38	14	—	52	Data not available		—	—

The Lepers Act, 1898, has been applied to the whole of Burma, except the Shan States, from January 1st, 1899. The Rangoon, St. John's and Moulmein Asylums were appointed asylums under the Act.

There are regulations forbidding lepers to prepare or sell certain foods, drinks, drugs, clothing, &c.; or to bathe, wash clothes, &c.; or to drive, conduct or ride in any public carriage plying for hire, other than a railway carriage; or to exercise the occupation of a cheroot-maker, washerman, or milkman.

The following suggestive note by Captain E. R. Rost, I. M. S., who is working at leprosy in Burma, on „The Cultivation of the Ba-

cillus Leprae and the Manufacture of Leprolin and its action in Leprosy", is inserted here owing to its interest:

„Just as there is a class of Bacteria which will not grow in the presence of oxygen, so is there a class of Bacteria which will not grow in the presence of the salts of chlorine: this class of Bacteria is the acid-fast series, of which tuberculosis, leprosy, and Lustgarten are pathogenic.

„About two years ago, while working at the antagonism between pathogenic organisms, I came across a peculiar law or classification of pathogenic organisms which was after the style of Mendelejeff's Law of the periodicity of the elements[1], and it was while working this out practically that I found the way of cultivating the acid-fast group of Bacteria. According to the arrangement of this law the organisms, B. Tuberculosis, B. Leprae and B. of Lustgarten corresponded to the Halogens, Chlorine, Bromine and Iodine. I therefore tried to extract the Chlorine salts from nutrient media and accomplished this by distillation of beef extract in a current of superheated steam from an autoclave, and later on by simply dialysing through an animal membrane.

„I found that this medium smelt strongly of beef, or if it was made from fish, smelt strongly of fish, and that in this medium, the Bacillus of Leprosy or of Tuberculosis, grew with the greatest ease, the growth appearing as a white stringy heavy deposit at the bottom of the tubes after one er two days cultivation at 100° F., which was hard to shake up from the bottom of the tubes and that when it was shaken up it appeared as a curly white stringy growth. The bacillus thus grown was found to have all the characteristics of the Bacillus Leprae in its resistance to acids, its irregularity of structure, its beady appearance, its size, and was found to be motile and to multiply by spores as well as by fission.

„ For some time I failed to grow it on solid media, but afterwards by prolonged dialysis of nutrient agar while it was kept hot for days, produced a medium containing no salts of chlorine, in which the bacillus grew with the greatest ease, and appeared as white or slightly yellow colonies which after some days became raised somewhat after the style of tubercle cultures.

„I cultivated quantities of the Bacillus of Leprosy in Pasteur flasks for a month, and then produced a leprolin, after the style of the manufacture of tuberculin, by heating the cultures at 100° C., and then filtering through a Pasteur filter and preserving in glycerine. I have since modified this procedure by not heating but by refiltering the culture several times trough a Pasteur filter, which is sterilized each time, reducing the bulk by concentration in a vacuum and then adding glycerine, thus producing a more powerful toxin.

„The first time I injected a case of Leprosy with this material, I only used five c. c. and there was an obvious reaction, I then used 20 c. c. and the reaction was as follows:

„There was a marked and rapid increase in the pulse rate, the

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1) This law has not been published on account of its not having been found to be of any use until the above experiments were started.

respirations, and a rise of temperature of from 100° to 105° F., while all the anaesthetic patches became red swollen and painful and hot, and the patient complained of malaise, heat and burning in the affected parts.

„These symptoms subsided in one or two days and then there was noticed a return of sensation in some of the anaesthetic patches as well as a reduction in the size, and colour of the affected parts.

„The first case I injected, a Chinaman, has now no symptoms of the disease left; he was injected three times, at intervals of about a fortnight, and his sensation which was entirely lost in the legs, on the face and on the ears, has now completely returned, while nodules in the ears, patches on the legs and on the face have now disappeared.

„I have injected now thirty-one cases, and in most of these there has been very marked improvement in their condition, some have been injected once, some twice, and some three times, and those injected three times show the greatest amount of improvement. They all say that they feel lighter on their legs after the injection and that it relieves their pains and itching sensation of the skin.

„The reaction in all these cases has been similar, in one or two instances there was no marked reaction, and these were slight and possibly doubtful cases of the diseases.

„This is not the time to go into details, but it appears evident that there is (1) no danger attached to this method of treatment, (2) that it has a marked reaction in the disease, (3) that is has greatly improved some and apparently cured one case, (4) that the experiments show that Leprosy is probably prevented by the consumption of salt, as it will not grow in the body in the presence of salt, and that therefore the treatment by the injection of Leprolin should be supplemented by the application of salt ointment to the skin and the consumption of large quantities of salt, (5) that the experiments of which this line of investigation is merely an offshoot forms an entirely new field for research, (6) that the reason why the injection of Leprolin does not create such a disturbance as the injection of Tuberculin is to be found in the fact that the bacilli in Leprosy are all in the skin and subcutaneous tissues and nerves except in advanced cases and not in the internal organs as in Tuberculosis.

„Observations and treatment are being continued.

„Leprolin can be obtained on application, and I expect to have produced a large supply of it by the middle of next month.“

Central Provinces and Berar.

There are several leper asylums, details of which are as follows:

Name of asylum	District	Number of inmates	Date of erection	By whom maintained
1.	2.	3.	4.	5.
Nagpur.	Nagpur.	26	1903	By Government. There is an accommodation provided for 250 inmates.

Name of asylum	District	Number of inmates	Date of erection	By whom maintained
1.	2.	3.	4.	5.
Nagpur.	Nagpur.	8	Date not given probably before 1897.	By Mission.
Wardha.	Wardha.	18	1895	Managed by Dr. Revie, Free Church of Scotland Mission.
Patpara.	Mandla.	23	1897	Church Mission Society.
Harda.	Hoshangabad.	19	1897	Christian Mission.
Raipur.	Raipur.	64	1898	District Council.
Dhamtari.	Do.	100	1900	Mission.
Mungeli.	Bilaspur.	72	1897	Do.
Chandkuri.	Do.	416	1897	Do.
Champa.	Do.	35	1902	Do.
Sambalpur.	Sambalpur.	24	1887	Endowment, being the rent of Mr. Goodridge's bungalow and by private subscriptions of residents and by mission.
Kothara.	Ellichpur.	23	1897	Kurku mission.

The Government asylum recently opened at Nagpur was established to provide accommodation for pauper lepers dealt with under Section 6 of Lepers Act, 1898. The Kothara asylum is intended for lepers among the hill tribes. The others are not reserved for any particular class of lepers, but the inmates are nearly all paupers.

It was recently noted that lepers were not being sent from a number of districts to the Nagpur asylum, and a circular was issued to the Deputy Commissioners on the subject.

Regulations have also been made in accordance with Section 9 re lepers and sale of food, washing, public carriages (other than a railway carriage).

Coorg.

There is no Leper Asylum in Coorg, where leprosy is practically unkonwn. Lepers Act, 1898, not extended to Coorg.

Lieutenant-Colonel D. S. S. Bain, I. M. S., Civil Surgeon of Coorg, has kindly sent me the following Report:

1. Area of the Province 1582 square miles.
2. Population (census of 1901) 180 607.
3. Number of Lepers — 6 males and 3 females.

Of those only 3 males and one female can strictly be called inhabitants of Coorg, the remainder are residents from the plains.

4. Means taken to deal with the Disease. No special means are taken.

Hyderabad (Native State).

There is no leper asylum; the provisions of the Lepers Act have not been adopted, and there are no regulations.

Indore (Native State).

On leper asylum at Sehore containing 32 male and 20 female in-

mates, in charge of Résident Medical Assistant. The Begum still contributes to its maintenance. No other leper asylum in Central India. There is a poor-house at Bangangar outside Indore City where 40 lepers are fed at State expense. Provisions of Lepers Act nowhere applied, nor any regulations.

Kashmir (Native State).

On leper asylum at Srinagar, with 145 inmates. Provisions of Lepers Act, 1898, not adopted. No regulations.

Madras.

Lepers Act, 1898, not in force. No regulations. There are several leper asylums.

Leper Asylums	Class of asylum	Date of opening	Accommodation available	Special objects or characteristics of the asylum
1. Government Leper Hospital, Madras.	State.	1841	246	To afford a home to those lepers who wish to avail themselves of the shelter provided and thus bringing about voluntary segregation.
2. Palliport Lazaretto.	Do.	1728	48	
3. Leper Asylum, Calicut.	Basel German Mission.	1894	27	
4. Jesuits' Leper Asylum, Mangalore.	Jesuits' Mission.	1890	24	
5. Basel Mission Leper Asylum, Mangalore.	Basel Mission.	1883	9*	Ditto.

*) This figure represents the number of paupers occupying beds.

Mysore (Native State).

Only one asylum maintained by Durbar in Bangalore, in which there are 18 patients. No asylum erected since 1897. Lepers Act, 1898, not in force, nor any regulations for treatment of lepers.

Nepal (within sphere of Indian influence).

One asylum on Bagmatti river near Pherfing (1893). There are 354 inmates, of which 225 are males, 129 females. It is a shelter for helpless lepers and receives no regular medical treatment. Lepers Act, 1898, not adopted.

North-West Frontier Province.

There are no leper asylums and the Lepers Act, 1898, is not in force. At Balakot in the Hazara district about 40 lepers are located in an isolated spot near a shrine. They receive a contribution from local funds and supplement this by begging. They reside there voluntarily and are under no regular control.

Punjab.

There are seven important Leper asylums, details of which follow:

Asylum	Number remaining from previous year	Admitted during year	Total	Died	Left of their own accord	Remaining at the end of year
Rawalpindi	54	11	65	5	2	58
Tarn Taran (Amritsar District)	193	51	244	22	39	183
Amballa	18	11	29	5	6	18
Dakhni Serai (Jullundur District)	93	28	121	4	12	105
Dharmsala	18	8	26	3	3	20
Baba Lakham (Sialkot District)	32	4	36	—	1	35
Sabathu . . . . . . (see below)	—	—	—	—	—	—

No regulations for the treatment of lepers have been brought into force since 1898. It was decided in 1900 that there was at that time no case for applying the Lepers Act, or any part of it, to any local area in the Punjab. The want of asylum accommodation stands in way of any extensive application of the Act.

I am indebted to Mr. A. B. Kettlewell, Judicial and General Secretary to the Government of the Punjab for the reports from each of the leper asylums in the Punjab. The statistics of the Sabathu Leper Asylum, kindly supplied by Dr. M. B. Carleton, the Superintendent of the Asylum, are as follows:

Statistics Sabathu Leper Asylum for 1903.

Caste or Creed	No.	Name of Territory or State	No.
Europeans.	2	Simla.	4
		Baghat.	3
Brahmins.	16	Bashair.	4
		Maihlog.	3
Rajputs.	12	Kothar.	1
		Bágal.	5
Keniets.	24	Dhámé.	1
		Kunihár.	2
Koli.	7	Beja.	1
		Nalagurh.	4
Gujjar.	1	Mundi.	7
		Suket.	2
Chumar.	8	Sarmour.	2
Chimba.	4	Beláspur.	6
		Kángra.	5
Lohar.	5	Pattiála.	12
Domua.	6	Garhwál.	21
		Umballa.	2
Chanal.	3	Dehra Doon.	1
		Saharanpur.	1
Ord	2	Kullu.	5
Julaha.	4	Calcutta.	2
Total	94	Total	94

Rajputana (Native States).

In Jodhpur, while there is no regular asylum, 130 lepers are collected at Kaga near Jodhpur City and assisted by the State. In Alwar, there is a leper asylum for 4 persons, erected prior to 1897, but there are no inmates at present. Lepers Act, 1898, not adopted. No regulations.

United Provinces.

Under section 1 (4) of the Lepers Act (1898), the Act has been applied tho the districts of Allahabad, Benares and Lucknow, and to the Kumaun division. Under section 3 the Naini leper asylum (Allahabad), the Raja Kali Shankar asylum at Benares, the Almora leper asylum, the Lucknow leper asylum and the Srinagar asylum (Garhwal) have been appointed to be leper asylums under the Act, and the municipality and cantonment of Allahabad, the municipality and cantonment of Benares, the hill pattis of the Kumaun division, the municipality and cantonment of Lucknow and the hill pattis of the Garhwal district have been specified as the local areas, respectively, from which lepers may be sent to these asylums.

Notifications (1899) have also been issued under section 9, prohibiting lepers from following certain trades and doing certain acts within the Allahabad, Benares and Lucknow municipalities, the Benares cantonment and the hill pattis of the Kumaun division. It has not been deemed advisable to make any rules under section 16 of the Act. Action taken by municipalities in the direction of the suppression of leprosy has been confined to the issue of bye-laws prohibiting lepers bathing and washing clothes in certain places, or selling certain articles of food, and to prosecutions under sections 160 and 173 of the United Provinces Municipalities Act (1900). Some municipalities have contributed to the cost of leper asylums with their limits.

Name of asylum	Present number of inmates	Special objects or characteristics	Which maintained by missionary bodies
Almora.	84	—	Partly under missionary management.
Pithoragarh.	4	—	Maintained by missionary bodies.
Srinagar.	4	—	—
Bahraich.	14	Maintained with the the object of segregation.	—
Agra.	75	—	—
Lucknow.	15	—	—
Rai Bareli.	64	The Jail leper ward wehre leper convicts from the whole province are concentrated.	—
Moradabad.	21	—	Maintained by Edinburgh Mission for lepers, who give a yearly grant.
Budaun.	30	—	—
Bareilly.	12	Maintained with the object of segregation.	—

Name of asylum	Present number of inmates	Special objects or charakteristics	Which maintained by missionary bodies
Shahjahanpur.	11	Maintained with the object of segregation.	—
Benares (Raja Kali Shankar Asylum).	15	—	—
Dehra Dun.	119	—	Receives a yearly grant from the mission to lepers in India and the East, but is not a missionary institution.
Saharanpur (male).	22	—	Maintained by missionary bodies.
Saharanpur (female.	8	—	Ditto.
Roorkee.	50	—	Ditto.
Muzaffarnagar.	18	—	Under missionary management.
Naini (Allahabad district).	60	Maintained by the Allahabad charitable association.	—

Aden District.

I am indebted to Colonel J. S. Wilkins, D. S, O., I. M. S., Principal Medical Officer, for the following information:

Table showing the number of cases suffering from Leprosy treated at the Civil Hospital, Aden, during the last ten years.

Year	Total number	Remarks
1894	15	—
1895	15	—
1896	5	—
1897	15	—
1898	12	—
1899	7	Average annual.
1900	7	Attendance = 9.5.
1901	4	—
1902	6	—
1903	9	—

Dr. John C. Young of the Keith-Falconer Mission, Sheiku Othman, Aden, writes:

„On an average we have about ten cases of leprosy visiting our Dispensary in the year. Most of these are cases of Lepra maculo-anaesthetica, but occasionally one sees a case of Lepra tuberosa.

„In every case I find that the patient has come several days journey from the interior and that the disease is prevalent in the town or village from which he comes. Just now owing to the troubles in Turkish Arabia people are flocking down from the mountains and within the last fortnight I have seen 6 cases.

„While touring in the Hinterland of Arabia I saw several cases. In Misamur e. g. a village with a population of about 200, I saw over a dozen cases, whereas in El-Daregan which was the next large village there was not a single case. In the whole of the Salig territory I have never seen a case among the original people of the place but I have seen one or two imported cases from the interior.

„My experiences in the territory of the Sultan of Abyan were similar. No single member of the Fadhli tribe ever came to me suffering from Leprosy, but two leprous beggars came to my tent who had travelled 14 days journey down from the interior.

„My own opinion is that leprosy is carried like malaria either by the mosquito or some other parasite and that until the medium be discovered no permanent advance will be made towards its extinction“.

I will here refer to Mauritius and the Seychelles, although these islands are geographically included in Africa. Politically, however, they were at one time more or less connected with India.

Mauritius.

I am indebted to Dr. H. Lorans, Acting Director of the Medical and Health Department of Mauritius fo the following information:

„All lepers admitted in the Government Hospitals are as soon as possible transferred to a private hospital called the St. Lazare Asylum unter the care of nuns belonging to the Community of „Notre Dame de Bon et Perpétuel Secours“; that institution is maintained by private endowments and grants and receives a contribution from the Poor Law Funds of Government in proportion to the number of paupers treated.

„The type of the disease met with is more frequently the tubercular, but the anaesthetic variety is not infrequent.

„The number of patients treated last year in the St. Lazare Asylum was 146 of whom 78 belonged to the general population and 68 to the Indian population; 114 were males and 32 females. There were 23 deaths among these patients, while 18 were discharged at their request as segregation is not compulsory except in the case of lepers undergoing a term of imprisonment.

„Though the prophylaxis of the disease has from time to time engaged attention, there is no special restrictive legislation concerning lepers who occasionally travel by rail and also use public conveyances A few regulations exist however by which lepers are precluded from engaging in certain trades or remaining in certain shops and bazaars where food products are sold.“

Dr. Lorans annexes two extracts, one from Dr. Chastellier's Report on the Medical and Health Department for the year 1900, which runs as follows:

Leprosy: Twenty cases only (6 tubercular and 14 anaesthetic) were temporarily admitted in Public and Prisons Hospitals prior to their transfer to the Leper Asylum, which was invariably done in cases of prisoners or patients willing to be sent to that Institution. Others had simply to be discharged to go home as there is no legal power to segregate even pauper lepers in this place.

The Asylum in question is a charitable Institution subsidized by, but not under the direct control of Government.

No reliable figures are forthcoming as to the number of lepers in the Colony, — although it is hoped this information may shortly be expected from the Census Commissioner's Report, but Dr. Chastellier believes that leprosy is on the increase.

He had occasion in 1894 and 1895 to report on the manner in which St. Lazare Asylum was managed, in the last report, (No. 183 of 11. 4. 95). He suggested that steps should be taken to remove the Asylum to a healthier and more isolated situation than St. Lazare, pending the introduction of a Law providing for the compulsory segregation of lepers.

In his annual report for 1897, he again referred to the subject and pointed out that it must sooner or later force itself upon the attention of Government.

Having had cognizance in March 1898 of the conclusions of the International Conference on Leprosy held at Berlin in October 1897, he availed himself of the authoritative statements then made to urge upon Government the desirability of at least introducing a law to provide for the isolation of the Asylum patients as a means of confining the evil within certain bounds. Although leprosy is of more common occurrence, in this Colony, among the poorer classes of the Community, yet it cannot be said that it is confined to that class alone, for the disease is conspicuous among members of the well-to-do classes.

The other from the Report of Dr. Lorans on the Medical and Health Department for the year 1902:

Leprosy: Sixteen cases of that complaint were temporarily treated in the Public Hospitals. According to a return kindly supplied to him by the Poor Law Commissioner, 44 admissions for that disease took place at the Hospice St. Lazare, and the total treated in that Institution during the year was 162.

Seychelles.

Dr. R. Denmann, Chief Medical Officer of the Seychelles, writes to say that there is a small asylum on one of the islands in which pauper lepers are segregated. There are only nine patients there at present and the type is in all cases tubercular.

Leprosy here is not uncommon, but is seldom seen, as families who happen to number a leper amongst them, always hide away their unfortunate relation, as though they were ashamed of him; and it is only when they are reduced to their last penny and can keep him no longer that they appeal to the Officials to look after him, and he is sent to the Asylum.

Ceylon (and Maldive Archipelago).

In a letter which Dr. Allan Perry, Principal Medical Officer of Ceylon, has kindly favoured me with, when sending the reports which follow, he states the cases of leprosy are almost entirely confined to the east, south and west coasts of Ceylon, the northern coast is fairly free. There are very few cases inland.

Since the introduction of the Leper Ordinance in the year 1901, 207 know lepers are under observation for whom accommodation is not available as yet at the Leper Asylum. These will have to be added to Dr. Meier and Phillips's figures as to the number in Asylums, but he is sure that this total does not represent the true number of lepers in Ceylon, which must be greater. The number of lepers treated in the General Hospitals, Dispensaries and Jails of the Island during 1903 was 111.

The estimated population of Ceylon in the following years was:

1900 . . .	3 612 303.
1901 . . .	3 619 208,
1902 . . .	3 685 267,
1903 . . .	3 740 562.

In answer to a question of mine re the Maldive Archipelago which is under British protection, Dr. Perry regrets to say there are no records known to him as to the incidence of leprosy in those islands. There is no Medical Department nor is there any person with a knowledge of Western Medicine living there.

Dr. W. H. Meier, the Medical Superintendent of the large Leper Asylum in Colombo adds:

The total number of cases of Leprosy reported in 1900 was 635, against 506 in the previous year, being an increase of 129, but the total number of new cases only exceeded by two those reported in 1899. In 1901, the cases reported were 590, being a decrease of 45 cases. The number of cases reported during the year 1902, when the Leper Ordinance providing compulsory isolation came into operation, was 560 with a decrease of 30 cases. During the past year (1903) 73 new cases were under the Ordinance isolated in the Leper Asylum.

The estimated population of the island at the end of 1902 was 3 685 267, the total number of lepers reported was 560, giving a percentage of 1,51 per 10 000 of the population.

There is at present a large Asylum at Hendella near Colombo in the Western Province affording accommodation for 332 lepers and a leper-ward for 16 patients at Kalmunai in the Eastern Province. It is very favourably situated as regards isolation, environment, and hygienic conditions, and consists of 20 well-ventilated wards, on the pavilion system, including an Infirmary for the separate treatment of sick lepers. The male and female lepers are kept separate. There are at present 235 male and 65 female inmates.

Voluntary segregation of lepers was observed in the Colony since the Dutch occupation, the present Asylum having been founded in 1708 but no Government Acts, Municipal laws and regulations were in operation for the suppression of the disease till 1901, when a Leper Act was passed during the year at the instance of the Home Government following the recommendations of the Berlin Conference of 1897, for the compulsory segregation of lepers, the disease having been authoritatively declared as contagious.

a) The Leper Ordinance No. 4 of 1901 providing for the segregation and treatment of lepers is annexed (see Appendix III).

b) The Regulations under the Ordinance for the suppression of Leprosy in the island provide for the removal of lepers to the Asylum or their home — isolation if allowed, and are as follow:

1. For the purpose of reporting to the Governor, as provided in section 7 of the Ordinance No. 4 of 1901, the case of a suspected leper, the Principal Civil Medical Officer shall require such person to attend at any place and hour that may be appointed by him for inspection and examination, or direct a duly qualified Medical Officer to enter tho residence of such person and to examine him. It shall be the duty of such person to submit to such examination.

2. Upon the Governor ordering the leper or alleged leper to be removed to and detained in a leper asylum, as provided in Section 8 of the said Ordinance, the Principal Civil Medical Officer and a officer of the Police shall give effect to such order.

3. The isolation and medical treatment of a leper or alleged leper may be allowed at his own place of abode on the following conditions:

a) If the place of abode stands apart from other dwellings, and is not a shop, bakery, laundry, or house in which marketable goods are stocked or sold;

b) If the patient can be isolated in such abode in a separate apartment, with separate bathroom and water-closet;

c) If satisfactory arrangements can be made to separate the bedding, clothing, eating utensils, &c., of the patient from those of other inmates; to wash and disinfect his bed-linen and clothes; and to provide for personal and medical attendance on him;

d) If provision is made for a Government or Municipal Officer visiting the patient periodically;

e) If all the expenses of living in such abode under such conditions be borne by the patient.

4. A breach of any of the above conditions shall be reported by the Visiting Officer aforesaid to the Principal Civil Medical Officer, who shall thereupon submit to the Governor a full report of the case. The Governor, if he thinks fit, may direct the patient to be removed to and detained in a Leper Asylum, as provided in sub-section (2) of section 9 of the Ordinance.

1. There are two asylums in the Island, at Hendella, Western Province, and Kalmunai, Eastern Province, for the segregation and treatment of lepers.

2. The Hendella Asylum is provided with 332 beds of which 278 are for males and 54 for females. The Asylum at Kalmunai consists of two wards with beds for 8 males and 8 females respectively.

The Government has in contemplation the extension of the Hendella Asylum in view of the increasing number of admissions and of making it the central asylum for all lepers in the Island.

3. The daily average of inmates in the Hendella Asylum during

the last three years since the introduction of the Leper Ordinance has been 272,97 in 1901, 281,13 in 1902, and 290,83 in 1903.

4. The occupation of lepers in this Institution is of a light nature compatible with their physical condition and the state of their disease, the inmates being chiefly employed as assistants to the attendants in keeping the wards clean, sweeping the garden and trimming the paths. No industrial work is done in the Asylum.

5. Lepers are not allowed to travel by rail or steamer unless conveyed by order of Government in special instances.

6. Lepers are not treated in general Hospitals, Lunatic Asylums and Prisons in the Island, but are at once sent on to the Leper Asylum (see Appendix III).

Dr. R. H. Phillips, who is in charge of two wards in the Eastern Province of the Island of Ceylon, reports of follows from Batticaloa:

Statistics. (a and b) according to official reports (the latest) there were 57 lepers in this district and 11 in his Hospital (55 males and 13 females).

Methods employed to cope with Leprosy between 1897 and 1903.

a) and b) All Medical Officers in Charge of Hospitals and Dispensaries were required to report all cases of leprosy occurring in their practice, but anything like effective isolation or removal to an Asylnm was not, to his knowledge, carried out till Leper Ordinance No. 4 of 1901 came into operation. The lepers are now examined by Medical Practitioners appointed under Section 2 of „The Lepers Amendment Ordinance" 1902, and reports forwarded to His Excellency The Governor according to whose final decision those who require admission into an Asylum are removed and those in the non-infective stage are isolated in their own homes.

1. There are only two wards attached to the Hospitul in his charge for treatment of lepers — one for males and the other for females.

2. The numher of beds assigned to each ward is 8. The accommodation for male patients is inadequate. They are well provided with all the necessary equipment &c.

3) Fluctuations in the number of lepers.

Year	No. reported by Headmen	Remarks
1896	90	These are as reported by Headmen, and subject to errors of diagnosis, & c.
1900	67	
1901	69	
1993	68	Ditto.

4. The lepers in the District are mostly cultivators and mendicants and a few petty traders. There is only one, to his knowledge, a

teacher in a Mission School who has now of his own accord and under advice isolated himself.

5. As regards transport by Steamers &c., states he that he knows of only one case sent here by Steamer from Colombo and returned the same way.

No lepers are admitted into the Civil Hospital.

Federated Malay States.

Mr. Aldworth, the Acting Secretary to the Resident at Selangor, has sent me a Report on Leprosy in Selangor, kindly compiled by Mr. E. A. C. Travers, State Surgeon, Selangor, and which runs as follows:

In the State of Selangor, Leprosy is most prevalent among the Chinese; in a very few cases are either Malays or Tamils attacked by the disease.

Although many Chinese are affected with Leprosy when arriving in the States from China there is no doubt but that cases do originate locally, children born in the country occasionally contracting the disease.

The type of Leprosy observed locally is mostly of the mixed nodular and anaesthetic description and it usually leads to extensive mutilation and deformity.

During the last ten years some 17 cases have been discharged from the Asylum apparently cured, but it is possible that the improvement was only of a temporary nature.

In the year 1893 a suitable asylum for the segregation and treatment of lepers was built in an open space of waste land, about $2^3/_4$ miles from Kuala Lumpur.

During the same year the quarantine and prevention of diseases ordinance was passed, Regulation III of 1893, in which powers were given for the removal of any leper to the Asylum on the written order of a Magistrate.

Since that date the nnmber of lepers treated in the Asylum have been as follows:

Year.	Admissions.	Total treated.	Percentage of deaths.
1894	89	156	8,97
1895	123	194	13,40
1896	92	194	10,04
1897	96	234	22,22
1898	104	253	17,78
1899	96	245	20,40
1900	124	246	18,69
1901	95	230	14,78
1902	107	232	23,27
1903	112	240	29,16

It will be seen that during the last seven years there has been no increase in the number of lepers treated in the Asylum. This is satisfactory in view of the fact that the population of Chinese in Selangor has steadily increased from 50 844 in 1891 to 109 598 in 1901.

The Leper Asylum consists of five large wards with cement floors, tiled roofs and brick pillars, each capable of accommodating 34 patients.

The wards, latrines, kitchens and other outbuildings are enclosed in a high wire fencing which, although presenting a sufficient obstacle to a weakly deformed patient, is not difficult for an able bodied man to get out of.

The patients are allowed to keep their various possessions in the wards by their beds and amuse themselves by rearing chickens and ducks. The enclosure is planted up with cocoanuts and has a picturesque appearance.

The greater number of lepers come to the Asylum and apply for admission, some others are brought in by the Police and there is a lock-up association ward for the reception of criminal lepers.

Some of the more able bodied of the lepers run away from the Asylum at night and after remaining at liberty for a few days, come back to the Asylum and are readmitted. In this way one individual has been admitted to the Asylum as often as six times during the year. The figures shewing the number of admissions are therefore misleading, the actual number of individuals being much less than that shewn as the total number of admissions.

Besides the lepers under treatment at the Kuala Lumpur Asylum there are three leper women at the Asylum in Singapore.

As a rule, no female lepers are treated in the Kuala Lumpur Asylum.

Mr. S. Lucy, State Surgeon, Pahang, kindly supplies this Report:

The State of Pahang covers roughly 20000 square miles and has a population (estimated by census in 1901) of 84113.

The population is divided into the following groups:

Malays	73462
Chinese	8695
Tamils	1227
Europeans and Eurasians .	180
Other nationalities	549

A return submitted at the latter part of 1899 by the Officers in Charge of the various districts gave 168 as the approximate total number of lepers then in the State, of these three were Chinese, and 165 Malays.

The figures relating to leprosy are compiled from estimates made by the native headmen of the many sub-districts, and are therefore, only approximately correct. Of the four districts, the Officer in charge of two reports that the disease „is not supposed to be on the increase“, one reports that the disease is „spreading“ and one states that there are no lepers in his district.

He cannot supply recent figures, nor is he in a position to say how far the above figures are reliable but the Malays are well acquainted with the disease and lepers, and lepers are marked men in their communities.

St is probable that there has been no appreciable spread of this disease during the past four years.

He has been in medical charge of the State for over a year and frequently travels through the Malay villages, and during this time has not seen a single case of leprosy amongst the people.

The number of lepers treated at the various State Hospitals during the last five years is as under:

1899	0
1900	1
1901	1
1902	7
1903	1

No particular measures are taken to deal with the disease in Pahang. Powers exist for the enforced segregation and isolation of lepers and can be exercised by any Medical Officer of Health who certifies a case as being a danger to the community, this power has never, he believes, been used in Pahang, during the past fifteen months two lepers (Chinese) have been at their own request transferred to a leper asylum in the neighbouring State of Selangor.

Voluntary isolation is in some measure practised by Malay lepers and they are shunned to some extent by the general community, though it cannot be said that segregation is in any way attempted.

No measures of enforced segregation or isolation of lepers are as far as he is aware under immediate consideration, nor are such at the present time, he thinks, advisable.

Mr. E. C. H. Wolff, Acting Secretary to the Resident at Negri Sembilan, writes from Seremban, that at present there are about 25 lepers in that State who are shortly to be retained in the Leper Asylum at Kuala Lumpur for treatment.

Britisch North Borneo.

Writing from Labuan, Dr. R. E. Adamson kindly informs me that some years ago all the lepers (Chinese) were sent to the Leprosy Station, Sandakan, and since then he has not seen a case. He can safely state that Leprosy does not exist amongst the natives of this island (they are large fish-eaters) and no cases have presented themselves to him from amongst the Chinese.

Hong-Kong.

In a letter received from Mr. Secretary Lyttelton of the Colonial Office, London, I am informed that there is no legislation on the subject of Leprosy in this Colony, and it would appear from the Medial reports that the disease is not very prevalent, as only two or three cases a year in the Hospital returns. I may add that these figures do not probably represent the actual incidence of leprosy in Hong-Kong, but only the cases that come into Hospital.

Wei-Hai-Wei.

Dr. Herbert J. Hickin is good enough to write from Wei-Hai-Wei that since his appointment there in June last, no case of leprosy has

come - under his notice. But he has reason to believe that it does occur to some extent in the more distant towns and villages of the Dependency. It is probably not very often seen and of a mild anaesthetic nature.

He has seen much Leprosy in the more Southern parts of China in past years.

Africa.

South Africa.

Leprosy in this area will be dealt with separately.

The Gold Coast.

I am indebted to M. Secretary Lyttelton, Principal Secretary of State for the Colonies, for the following details concerning Leprosy in the Gold Coast, Lagos and Sierra Leone.

There is no law in force in the Gold Coast for the segregation of detention of lepers. In 1902, at the Government hospitals there were three admissions, with three death, from nodular leprosy, and four admissions, no deaths, from anaesthetic leprosy. There were no cases remaining under treatment at the end of the year.

In the Northern territories of the Gold Coast, leprosy is stated to be of rare occurrence.

Lagos.

There is no law in force in the Colony of Lagos for the segregation or detention of lepers. Among the Hausa portion of the population the disease appears to be thought nothing of, but the Yorubas regard it as contagious, and are so convincend of its hereditary nature that a leprous taint will form a bar to marriage. At present there are leper quarters outside the large towns, and segregation is carried out by the native authorities.

There is a leper asylum in the Colony constructed of native houses. It is worked under a voluntary system, but little use is made of it. In 1899, 13 patients were admitted there, and in 1900, the last year for which any statistics have been received from the Colony, 22 patients were admitted.

Dr. Henry Strachan, the principal medical officer, informs me in addition that Leprosy in all its so-called forms exists all over the Colony and Protectorate, and has apparently been known for centuries. The natives believe it to be contagious. Among the natives in the Hinterland, segregation is to some extent in force, lepers being compelled by native custom to live in outlying farms and not in villages and towns.

It is in contemplation by the Lagos government to build and support a larger leper asylum soon.

Sierra Leone.

Dr. W. T. Prout, Colonial Surgeon, reported to the Colonial Office in 1900 that is was an exceedingly difficult matter to obtain exact information and definite statistics as to the extent to which Leprosy prevailed in Sierra Leone, owing to the small number of medical men,

but the general opinion appeared to be that the disease was one which was not to any extent prevalent there; and this opinion was supported by the fact that in the two Incurable Hospitals at Kissy, there were only seven lepers, one female and six males. In the case of the former, the disease was said to have been acquired in Freetown, while in the latter, one occurred in a political prisoner from Ashanti and another in a man from the Kroo Coast, leaving only four acquired locally. Of these four, three were said to have been acquired in Freetown and Kissy while the fourth came from the Timiny country. These seven cases have been under treatment since 1884, 1889, 1891, 1892, 1897, 1898, and 1899 respectively. It is evident that if this represents the prevalence of leprosy in the locality, only five cases have occurred since 1884, and that the disease must be a somewhat rare one; and it is probable that the local conditions are not favourable to its spread, Dr. Renner, whose experience of native disease is very considerable, stated „that this disease is not prevalent in Freetown and the Colony. It is not prevalent in town and when seen, it is among the labouring classes such as Timinees, Mendies and Krooboys. It cannot be regarded as a common disease here".

The inmates of the Incurable Hospitals were principally syphilitic cases, strumous cases or intractable ulcers, paralytics and sufferers from old age and debility who have no friends to look after them. After careful enquiry at the Male Incurable Hospital, the Medical Officer in charge saw no reason to believe that the presence of lepers there was prejudicial to the other inmates, and there was no history of any inmate having developed the disease by infection from a leprous inmate, although no special precautions appeared to have been taken to keep them apart.

It was evident that the conditions, so far as leprosy in the Colony was concerned, did not bring it within the category of countries mentioned in Resolution I (See Enclosure 1) „were leprosy forms foci, or has a great extension", and consequently it was probable that the system of partial isolation which existed in the Male Incurable Hospital sufficiently answered the purpose of preventing the spread of disease in the community; and it was douptful whether, in view of the limited extent to which it prevailed, et was necessary to incur the expenditure required to provide a special isolation hospital for lepers. The isolation at the M. I. Hospital might be made more complete by reserving a portion of the dormitory; by seeing that plates and other utensils used by lepers were reserved entirely for them and by keeping them apart from the other inmates by day in a separate compound.

Seeing, however, that the number was so small Dr. Prout inclined to the opinion that to enforce the latter very strictly would be productive of very great hardship, quite incommensurate with any advantage to be gained.

Cases of leprosy and other incurable disease can at present be dealt with under Ordinance No. I of 1864 (which Dr. Prout was sorry to say had to a large extent been allowed to become a dead letter) if found wandering about or begging, and if this Ordinance were extended so as to provide for the compulsory notification and removal

of cases of leprosy and made to include the cases described in paragraphs 16 and 17 of the Secretary of State's Circular Despatch, he was of the opinion that the interests of the community so far as the danger of infection from Leprosy is concerned would be sufficiently safeguarded. Provision would also have to be made under the Ordinance for better class individuals, who could satisfy the authorities that they were able to procure for themselves proper isolation and medical treatment.

The question of the danger of the importation of cases from the Protectorate would also have to be considered, and also the steps which might require to be taken locally.

From the information in his possession up to the present, he was inclined to believe that it would be found that leprosy was much more prevalent in the Protectorate than in the Colony and if it was found to exist to such an extent as to require segregation of lepers, the question of forming a leper community would have to be considered. The only way in which the conditions laid down in the Secretary of State's despatch could be realized, while at the same time complete isolation was provided for, would be to utilize one of the small islands of the Colony for this purpose.

As to Leprosy in the Protectorate, the following points of interest are taken from the Reports (1900) from the following medical officers:

Dr. Hood, Ronietta District.
Dr. Ward, Karene,
Dr. O'Flaherty, Panguma,
Dr. Davson, Bandajuma and
Dr. Jarrett, Sherbro.

Dr. Prout states that in the two districts to the west of the Protectorate, the District Surgeons agree in reporting that while their own personal experience is limited, the disease is fairly common.

Dr. Hood states: „Leprosy exists fairly extensively throughout the districts, in fact I am told that most towns have their leper. The native recognizes that the disease is infectious and the segregation of the sufferer so far as I can gather is complete, and as no native medicine has been discovered to produce any effect on the disease, the care of thoroughly isolating the patient undoubtedly prevents the disease getting too great a hold on the community. On this point the aboriginal appears to have attained the wisdom of his civilized brethren.“

Dr. Ward states: „The disease is regarded by the natives as distinctly contagious, and the strictest isolation is practised, sufferers from the disease often being sent miles into the bush.“

On the other hand the reports from Sherbro and the eastern part of the Protectorate are much more meagre.

Dr. Jarrett states: „That he has never seen a case“ and as he has been in Sherbro for about 19 years it is clear that the disease cannot be prevalent. He believes, however, that the disease exists, and that the natives take no precaution to prevent its spread.

Dr. O'Flaherty report that he has not seen a case and that it would appear to be very rare. He is evidently unable to give any

opinion as to the precautions which the natives take, but as chronic cases of disease are sent to the fakais or small hamlets in the bush, it is evident that in a case of leprosy at least a partial isolation would be enforced.

Dr. Davson, Bandajuma, has seen one case, but from the difficulty he has had in obtaining information it is apparently not a very prevalent disease. He is informed that the natives take no precautions such as isolation to prevent it spreading.

With this information before him, Dr. Prout adds that, the questions to be considered are: a) Is it necessary to take any steps to enforce compulsory segregation of lepers the Protectorate? and b) Is there any danger of importation of cases from the Protectorate into the Colony, and if so, what steps should be taken locally to prevent this?

With reference to a) he thinks it is clear that in those parts where the disease exists, sufficient precautions are taken by the natives themselves to prevent it spreading to any extent. He does not think it necessary to advise any legislation so far as the Protectorate is concerned. In his opinion it would not be productive of good to interfere as yet with the habits of the natives, but should cases occur where it is evident that precautions are being neglected a great deal may be done by the influence of the District Commissioners and the District Surgeons on the Chiefs and Heads of villages.

b) Considering the isolation practised in the Protectorate, the danger of the importation of the disease appears to him to be very small. Any attempt at medical inspection of all arrivals from the Protectorate could only be done at a cost quite out of proportion to the benefit to be gained. Any danger arising from this source can be met by providing for the compulsory notification and compulsory removal of all cases of leprosy occurring in the Colony. In the case of aborigines arriving from the Protectorate, and being discovered here with leprosy, provision could be made for their return to their own country, the Chief undertaking to see that isolation would be enforced.

With the additional facts now before him he sees no reason to modify the opinion expressed in the first part of this report that the system of partial isolation as it exists in the Male Incurable Hospital sufficiently answers the purpose of preventing the spread of the disease in the community. The suggestion as to a separate dormitory might he thinks be carried out with advantage.

He sees no reason at present to recommend the formation of a leper community.

Nigeria.

The field of the disease in the Western Soudan (Nigerian District) delimited by Mr. Tonkin to the International Conference held at Berlin in 1897 has since then been the subject of two papers by the same observer. In the earlier of these (7) he calls attention again to the great extent of the field and to the marked prevalence of the disease in it. The whole of the region to the immediate westward of Lake Chad that falls within the British Sphere, appears to be densely leprous,

and the writer thinks that, with the adjacent areas that fall under the influence of other Powers, notably France, it will be ultitimately recognized as among the greater leper fields of the earth.

As this district has since 1897 been the scene of more or less continuous military operations and in fact is hardly yet subject to effective administration, nothing of importance has been officially done, even to estimate the prevalence of leprosy and at the best it will probably be many years before any British Sanitary Authority is in a position to limit it.

The natives themselves look at the disease as contagious; but although most of these districts have in the past been subject to fairly highly organized forms of Mohammedan Government, no definite measures have been undertaken to limit its spread. The disease apparently is not feared. The collection together of lepers in smaller or larger communities which is a feature of the social life of Nigeria is not a sign of any general sense of the danger of contact with leprosy; but the result of social processes quite unconnected with any idea of sanitation. A begging community is an example of this. A leper begs, and as the Mohammedan public is generally free with alms, he is quite often able to save a considerable sum of money. When sufficient has been amassed he buys in the open market another leprous individual, a slave that is being sold by its owner on account of his inability to work, and sends him also out to beg. Two beggars naturally collect more than one, so more money is saved, and fresh leprous slaves are bought, till the house of the original beggar from being the quarters of merely a single leprous individual becomes the dwelling place of a whole community. There were many of these communities in the larger towns of Nigeria, and throughout the whole region visited by Mr. Tonkin, town and country alike, the disease was everywhere strongly in evidence.

The second paper (8) is an analysis of 220 Soudanese cases designed to illustrate in detail the conditions under which leprosy occurs in Nigeria. Of all the cases examined 125 were males and 95 females, all of course, belonging tho the native races.

Southern Nigeria.

Dr. Allman writes concerning this area that Leprosy is very prevalent in Southern Nigeria so much so that at Asaba, on the Niger, a settlement for those affected has been established and is efficiently looked after by Dr. D'Arcy Irvine, who in his report of 16th June 1903. states:

„The settlement is situated at a distance of about 2½ miles from Asaba and there are upwards of 30 lepers at present in residence. The present accommodation is only capable of containing 42, and the intention is to continue building until all the Asaba lepers are housed, these are said to total 200.

„The present arrangements are that each house is responsible for the supply of food to its leprous members, and that any one harbouring an inhabitant of the Leper Settlement is subject to a fine. Arrangements are being made for the supply of seed yams and a cer-

tain amount of stock to the Settlement, and if in time, the latter can be made self-supporting, a great source of difficulty will be removed. These is ample space both for building extension and farming and the soil appears to be good."

Dr. Allman attaches suggestions for proposed Legislation which is now under consideration.

Suggestion for Legislation re Leper Settlement.

1. Expenditure of Native Council, a Government fund for the appropriation of property for settlement, building and equipment.
2. For the detention of lepers at their own request or otherwise.
3. For the discharge of lepers from settlements.
4. For the recovery and punishment of lepers escaping from settlement.
5. For the punishment of persons harbouring escaped lepers, and for failing or refusing to disclose the whereabouts of escaped lepers.
6. If necessary for the segregation of the sexes.
7. For authority to take up lepers vagrant or otherwise.
8. Lepers not to be allowed to sell or otherwise dispose of articles of food, drink or clothing except amongst themselves. Not to carry on such trades as washman, tailor, shoemaker, or any occupation which concern the food, drink or clothing of the people generally.
   Not to practise prostitution.
9. Lepers to be supported when necessary by the "houses" or "quarters of the town" to which they belong. Penalty for failing or neglecting to do this
10. To enforce the continued isolation of lepers until medical sanction of liberty is given to them.
11. All lepers to be medically examined and registered before consignment to the leper settlemeut.

General rules for the inspection and management of settlements; appointment of, and powers of inspectors: Conduct of lepers in settlements; General management of settlement to be vested in the District Commissioner and Medical Officer and exercise of authority to discharge lepers subject to the decision of the Medical Officer.

British Central-Africa.

Dr. J. E. S. Old reports as follows: No statistics are available and medical work among the natives in such a new country as Nyassaland is necessarily limited. He has seen several cases of leprosy in villages on the shores ot Lake Nyassa and the Shire river, and it has been reported to him that an ulcerative disease, supposed to be leprosy, is very prevalent around Lake Shirwa, which is salt and has no outlet.

The disease also occurs at Mount Chiperoni, in Portuguese Territory, about 20 miles from any real river, but he says they eat a lot of fish, caught and sun dried during the dry season at the big rivers.

British East Africa and Uganda Protectorate.

Dr. Moffat has forwarded the following details: He fears that such information as he is in a position to give will be of little value for the purposes for which it is required. The reason for this is that hitherto their experience of the diseases affecting the aboriginal tribes of the country has been necessarily very limited; the greater part of the duties of Government Medical Officers consists in dealing with employers such as soldiers, police and porters, etc. These men are naturally all picked adults and they consequently do not afford a true index as to the diseases prevalent among the ordinary population, especially as the conditions under which they live are entirely different from those that obtaïn among the latter.

Dr. Moffat has been thirteen years in East Africa and the greater part of that time he has served in the countries on the west of the Lake Victoria. He has, however, from time to time been in touch with the medical work in the districts on the coast and his experiences would point to the following conclusions:

1. Leprosy is endemic and common along the whole coast line of British East Africa. In making this statement he excepts Somaliland of which country he knows nothing.
2. The disease is rare among the various tribes living between the Coast line and the Lake. He has himself never seen case among these peoples but for the reason above given, this fact does not exclude the possibility of its being present. If, however, it were common he thinks he would have come across traces of it.
3. In Uganda itself the disease is found but not to any great extent.
4. In that part of the Nile valley which is under the Administration of the Uganda Protectorate viz: as far north as Gondokoro — the disease he believes is very prevalent. The majority of the cases that have come under his notice in that country have been among the followers and former slaves of the Soudanese troops, who were imported into Uganda from the Nile valley; from this fact he assumes that there is plenty of it among the aborigines of the Nile valley.
5. No measures have yet been taken to deal with the disease in East Africa.

As to the Atlantic Islands, the following details have been received:

St. Helena.

Dr. W. J. J. Arnold, Colonial Surgeon, writes that there are only two cases of leprosy at present known to him in the Island. Both are old men, one of English parentage and the other a native of the island probably of Malay origin, and the disease is of the anaesthetic type and of more than ten years duration in both instances. Beyond instructing the household to take certain domestic precautions and keeping the patients as much apart from others as possible, no further process of isolation has been adopted.

Ascension.

Dr. John Andrews states that leprosy does not exist in the island.

America.

Canada.

I am in debted to Dr. Montizambert, Director-General of Public Health, Ottawa, for the following information:

The Canadian Government maintains a leper lazaretto at Tracadie, New Brunswick, in which there are at present 17 cases. Of these 3 are Scandinavian immigrants, 2 came from Barbados, and 1 from Bermuda. All these arrived in this country while the disease was either in the period of incubation or at such an early stage of development as to have escaped recognition. The remaining 11 cases are all of local origin. There are also on the Pacific Coast 2 Chinese lepers on a small island near Victoria at the charges of the municipalities from whence they came. These with 2 or 3 incipient cases on the Atlantic Coast, which are isolated in their homes and not yet sufficiently advanced to make removal to the lazaretto a necessity, constitute all the known cases of leprosy within the Dominion.

This disease has been present, endemically, in a comparatively small area on the Atlantic Coast for the last half a century or more, an average of about 2 new cases a year occurring which about balances the average number of deaths in the lazaretto. The number of local cases is somewhat smaller than is was a few years ago so the disease seems rather to diminish than to increase.

Dr. Montizambert has also forwarded to me a copy of the Quarantine Regulations of the Dominion of Canada (1898), from which I take the following reference to leprosy under Quarantinable Diseases. „With respect to leprosy it is the duty of every quarantine officer, particularly on the Pacific coast, to satisfy himself as to the fact of the presence or absence of such disease among the passengers; and in the event of any case of such disease being found, the person affected shall not be allowed to land, but must be taken back by the vessel to the place whence he or she came“.

Dr. A. C. Smith of the Tracadie Lazaretto has kindly supplied the following details:

Leprosy first appeared in New Brunswick in 1815 but it was not until 1844 that Government measures were taken to arrest the spread of the disease in this Province. A lazaretto was built on Sheldrake Island, on the Miramichi River, and in the following year it had eighteen inmates. Two others had escaped. In 1849 the lepers were removed to a new lazaretto in Tracadie. In 1851 thirty-seven lepers had been gathered in. In 1854 the Honble. Dr. Gordon was the medical attendant. In 1861 Dr. James Nicholson was appointed. He died in 1865 and Dr. A. C. Smith was immediately appointed to the position. When Dr. Nicholson took charge he found the lazaretto under the management of a Board of Health to whom had been given despotic power. Lepers were hunted like wild beasts, dragged from their hiding places, handcuffed

and thrown into what was a cheerless prison surrounded by a wall twelve feet high with a row of long iron spikes on the top to prevent escape. Dr. Nicholson threw down this prison wall and a better day began to dawn on the wretched inmates. Notwithstanding the existence of the lazaretto, segregation was not complete. At one time there were twelve lepers in the institution and eighteen others running at large.

The lazaretto is now under the gentle sway of Sisters of Charity who act as nurses and attend to the preparation of food and clothing. It is now a Lepers' Home; and in no part of the world are lepers so tenderly cared for by a paternal Government as in Tracadie.

For the last twelve yars segregation has been complete. The physician-in-charge keeps a record of families tainted with leprosy and visits them from time to time. There is no law in Canada compelling lepers to enter the lazaretto. The old Board of Health ceased to exist many years ago. The physician in charge advises the immediate friends and relatives of any leper he may discover; warns employers of labour, and the unfortunate leper soon finds himself ostracized and willingly enters the Home. As the result of very careful segregation leprosy is rapidly dying out here. From Tracadie, so long its hiding-place, no lepers have been admitted to the Institution for many years. Recruits come from outlying districts where Tracadie lepers had at one time removed, creating new foci of the disease.

Our lepers are French. Some English persons with no possible taint of leprosy are on our records as having contracted the disease here through contagion — some through working with lepers in lumber camps in the winter months.

The lazazetto is supported by an annual grant from the Federal Government. Municipalities, parishes, Provincial or Local Boards of Health, etc. etc. never interfere in the management of the institution or with our mode of segregation. The lazaretto is the only one oft he kind in Canada, with the exception of a very small one for Chinese lepers in British Columbia. There have been some cases of leprosy in Cape Breton, Province of Nova Scotia, among the immediate descendants of Scotch immigrants from the Hebrides „Scotland" arriving here in and about 1810, and among others infected by them. Some years ago all known cases were segregated at their own homes until they died, and the disease no longer prevails. Bacteriological examinations aided in differentiating from other diseases closely resembling leprosy.

There are twenty-six beds for lepers in the Tracadie lazaretto — but few now occupied. There has been a steady and rapid decrease in the number of our lepers for years. To careful segregation, aided by the improved condition of our people, I attribute the decrease.

Our lepers have no employment, but take exercise by outdoor life during a portion of each day; also in sailing in the harbour, shooting wild fowl, etc. etc. They are cheerful and seem contented. A good and varied diet, and warm clothing are provided.

Our lepers are never admitted to general hospitals, lunatic asylums, infirmaries, or prisons.

I know of no sporadic cases in Canada.

Removals of lepers from distant points are made by schooner, sail boat, horse, etc. etc. In no instance were Railway trains made use of for advanced cases. In a few cases a special fourth class car has been employed but the travelling public were not admitted.

British Columbia.

There are now only two lepers on D'Arcy Island. B. C. Both cases are Chinese (males), aged 20 and 30 respectively. The one of 20 has tubercular leprosy and is still fairly vigorous; the other has the nervous form of the disease and is getting quite feeble. The one has been four years on the Island, the other eight years. Both cases were discovered in British Columbia. The younger one came from Victoria and the other from Vancouver. The health authorities of Victoria have the care of the lepers but Vancouver or any other city or municipality has to pay for the maintenance of any patients sent from such city or municipality.

New Foundland.

Dr. R. Almon Brehm, Medical Health Officer writes that, so far as he is aware, leprosy is quite unknown in this country.

He has enquired of medical men who have practised in various parts of the island — and there seems to be no history, or tradition, of the appearance of leprosy at any period in the history of the country.

West-Indies.

Bermuda.

By the courtesy of Mr. Eyre Hudson, Colonial Secretary of Bermuda, I append the report supplied by Dr. Eldon Harvey who states that as far back as he has been able to push his investigations, there seem to have been always a few diseased persons, believed to be afflicted with Leprosy, five or six living at any one time. Probably some of these cases were syphilitics. Ten years ago there were eight such cases living, — one has left the Colony, and the others have since died. At the present time there is not a single certificated case of Leprosy in the Island, but he has reason to believe there are three persons now under observation and suspect of having Leprosy.

No law of segregation has ever been seriously thought of.

Jamaica.

Mr. Tonkin has been good enough to let me have the following abstract of a paper by Dr. Neish and himself, read before the Bristol Medical Society (9).

For many years the amount of leprosy has gradually diminished in Jamaica; during the last five, however, the decrease has been very marked. There is no arrangement for the enumeration of lepers; but the following table gives the annual admissions to the leper home at Spanish Town (the Segregation Hospital for the Island) since 1897, and the tendency or the figures may be taken as a safe indication of the general condition of affairs.

1896—97	40
1897—98	38
1898—99	20
1899—1900 . . .	27
1900—1901 . . .	19
1901—1902 . . .	9
1902—1903 . . .	--

The general diminution that has been evident for many years has no doubt been due in the main to the influence of the leper home; but the marked decrease since 1897 is the result of an operation of a law (Law 15 of 1896), which has had the effect of bringing all pauper and vagrant lepers into the Home. Up to 1897, the home was optional to the lepers, but matters are now so arranged that leprous persons possessing no visible means of support are compelled to enter.

The races open to infection in Jamaica are three, pure whites, coolies (an element imported to work on the banana and sugar plantations) and the deeply coloured and black. In the leper home these various elements are represented as follows — one person reputed to be pure white, 5 coolies, and the rest coloured and black, mostly the latter. Out of the 110 persons under supervision 66 are males and 44 females. The types of the disease follow the general rules observed elsewhere, the anaesthetic form preponderating. The intercurrent diseases that appear to have a special preference for the Jamaican leper are as usual, those that affect the skin and muscous surfaces, the conjunctival, pulmonary and intestinal for example, more or less continuous with it. They include Rhinitis and Ozæna, catarrhal and inflammatory infections of the lungs, bowel disorders and nephritis.

The period over which fatal leprosy extends works out for the Jamaica leper home at 10 years for the anaesthetic variety and 7 for the tuberculated. The average death rate in the Institution is 10%, and the diseases that usually terminate life are chronic diarrhoea, chronic nephritis, phthisis, chronic bronchitis, pernicious anaemia and syphilis, probably in the order named. No diseases other than leprosy are received into the Home.

It is estimated, of course in the absence of the means of enumeration the estimate is conjectural, but it is not likely to be very far out, that there are now not more than 300 lepers in Jamaica. The general population at present stands at somewhere about 750 000, so 300 will give a paper proportion of 4 in 10 000. It is certain that this, if anything, overstates the case.

I am indebted to Dr. **Numa Rat** for the following details:

The Leeward Islands.

The Colony of the Leeward Islands consists of the following islands Antigua, St. Kitts, Nevis, Dominica, Montserrat, Anguilla and the Virgin Islands.

The area and population are as follows

Island.	Area.	Population.
Antigua	108 sq. miles	35000
St. Kitts	68 „ „	30000
Nevis	50 „ „	12500
Dominica	291 „ „	26000
Montserrat	72 „ „	12000
Anguilla	35 „ „	4000
Virgin Islands	?	4500
		124000

Nevis is separated from St. Kitts by a strait which is about two miles in breadth at its narrowest part, but the distance between the two ports from which boats sail is twelve miles.

Anguilla is sixty miles north-west of St. Kitts.

Montserrat is 27 miles from Antigua.

No laws have been passed since 1897, dealing with leprosy. The „Leper Ordinance“, No. 9 of 1890, St. Kitts-Nevis, is the latest on the subject.

Asylums.

There are only two leper asylums in the Colony, one in Antigua, and the other in St. Kitts.

Antigua.

The following is all the information which has been supplied with regard to the Antigua asylum by the acting medical officer.

Admissions 1897—1903.

Year.	Males.	Females.	No. at end of year.	Deaths.
1897	1	1	31	?
1898	4	4	36	3
1899	8	—	40	4
1900	5	1	40	6
1901	1	3	37	7
1902	3	3	40	3
1903	—	—	30	10

There is no statement showing the number of deaths and discharges during the above period. But, as it is probable that there were no discharges, I have added a column showing the yearly mortality under that assumption.

The above figures show the following averages.

Average number in asylum		37,1
„ admissions	males 3,5 females 1,8	5,3
„ deaths		5,5

The proportion of deaths to the number of inmates is 14,8 per cent. There was an exceptionally high mortality in the year 1903.

The population of Antigua in 1901, which may be taken as the mean population for the period 1898—1903. consisted of 16000 males and 19000 females. There were, therefore, 37 lepers in the asylum to 35000 inhabitants or soughly about 1 in every 1000.

The census for 1891 reported that there were in that year 34 lepers under restraint and 11 at their own homes.

The census for 1901 did not furnish any particulars in this respect.

The admissions of males were twice as numerous as those of females in the asylum during the years 1898—1903, the former averaging 3,5, and the latter 1,8 yearly.

St. Kitts.

Dr. Rat has received a report on the leper asylum in St. Kitts from the medical officer, Dr. Foremann. He estimates that there are about 40 lepers in St. Kitts and Nevis besides those in the asylum who average 69,6 for the period 1898—1903.

The following are the returns of the institution for the years under consideration.

Year	Inmates	Deaths.	Births.
1897	63	7	—
1898	71	6	1
1899	76	8	—
1900	64	5	1
1901	63	7	—
1902	72	1	1
1903	72	11	1

These give 69,6 as the average number of inmates and 6,3 as the average annual mortality.

The mortality is 9,0 per cent. and is much lower than that of the Antigua asylum which is 14,8 per cent.

The mortality during the year 1903 was exceptionally high both in this asylum and in the one in Antigua, but is is neither explained nor even referred to by the medical officers.

The mean population of St. Kitts and Nevis for the period under consideration is about 42 000. The proportion of lepers in the asylum to the total inhabitants is therefore about 70 to 42 000 or roughly 1 in 600.

In 1899 — Jan. 1st — there were 65 lepers in the asylum — 37 males and 28 females.

It will be noticed that, as in the Antigua asylum where there were two males to one female, admitted on an average yearly, the male lepers are more numerous than the female.

Of the 72 inmates in 1903, 42 were males and 30 females.

The proportion of males to females among those admitted from Nevis corresponds with that given by the figure for admissions into the Antigua asylum, viz, 2 to 1, while there is but little difference between the numbers of the males and females who were admitted from

Many persons in the the island are affected with multiple ainhum, several of their toes having been lost from one foot, but these show none of the ordinary symptoms of leprosy. The toes, they say, were ulcerated before they fell off.

Barbados.

Dr. S. W. Knaggs, Colonial Secretary of Barbados, has sent me the following note: In Barbados which has an area of 166 square miles and an estimated population of 197 000 there are about 200 lepers inclusive of those in the Government Lazaretto which will accommodate 131. At present there are 116 lepers in the Lazaretto. 63 males and 53 females.

There is no compulsory segregation of lepers excepting in the case of those who are without visible means of subsistence, but a leper once admitted into the Lazaretto is not allowed to leave it.

A Bill is now before the Legislature to prohibit the landing of lepers in the Island and to prevent lepers engaging in any trade or occupation or entering any hotel or vehicle.

Leprosy is scattered throughout the Island and affects all races indiscriminately.

The disease appears to have been introduced into Barbados with the negro slaves brought from West Africa.

St. Vincent.

Mr. E. J. Cameron, Administrator of the Island, has written that the District Medical Officer in charge of Institutions reports:

„There are no means of knowing the number of lepers in the Colony. All the cases do not come to the notice of the Medical Officers. There is no compulsory segregation of lepers enacted. Those afflicted who offer themselves are cared for in a leper Asylum on the extreme point at one side of Kingstown Harbour. There are now 8 lepers in residence.

„He knows of 3 other lepers about the town. Probably there are less than 30 in the Colony."

There is no compulsory segregation, but there is a small Asylum in which at present 8 cases are under supervision.

Dominica.

I am indebted to Dr. H. A. Alford Nicholls C. M. G., whose contributions are well known, for the following note: Leprosy is, and apparently always has been, a rare disease in Dominica. A few years ago there were ten lepers in the island, since then three have died and he has not heard of any fresh case. Two of the cases that died were husband and wife. The wife became affected first and some years afterwards the husband contracted the disease, as is believed, from her.

Dr. Nicholls considers that Mr. Hutchinson's counsel to let loose the lepers segregated in those West Indian islands in which the disease prevails, in the opinion of many — whose knowledge of leprosy is not inferior to Mr. Hutchinson's — would be a deplorable step fraught with danger to the general community.

the island and who writes that he has been six months in his present district and has not seen a single case of leprosy.

During Dr. Rat's three years service in Dominica where he was at one time a district medical officer, and at another, in charge of the public institutions he saw only one case of leprosy. It was that of a coloured man suffering from tubercular leprosy. He never heard of any other case, and he believes it was the only one in the island.

It is strange that Dominica which is so near to many of the other West Indian islands where leprosy is very prevalent should be free from that disease. The conditions of life in that island are worse than in many of the others, and the poverty and unhealthy surroundings of the people in many of the country districts allow the development of such a disease as yaws.

There are two circumstances which may explain this exemption, or rather there are two conditions which obtain in the four other larger islands of the colony which are not met with in Dominica.

There is not as much intercourse between it and the other islands of the colony as between the latter. This is due partly to its greater distance from the est of the colony and partly to the fact that the majority of its inhabitants speak a French patois.

Another difference is the absence of Portuguese from Dominica. There were 208 Portuguese in Antigua and 299 in St. Kitts in 1891, and there were practically none in the other islands of the colony. But Nevis is really a part of St. Kitts, being divided from it by a strait which is only two miles wide, and Montserrat is in frequent communication with both these islands and with Antigua.

These are the only two differences which occur to me in this connection. Some of the Portuguese suffer from leprosy, but the disease is not sufficiently prevalent among them to explain its extension in Antigua, St. Kitts and Nevis where leprosy is commonest. As shopkeepers, they would be likely to communicate the disease to others, if those of the shop-keeping class were affected with the disease, but this is not the case.

Montserrat. Dr. Duke, medical officer of the public institutions reports as follows: „There are no statistics available as there are no institutions here for lepers and there are no cases in the Poor House or Hospital.“

Dr. W. G. Heath, medical officer of No. 2 district writes „Leprosy is not common here. Personally I only know of about half a dozen cases none of which are in any way segregated or under any treatment. There may be other cases of which I do not know.“

The census for 1891 returned 9 cases only of leprosy for the wohle island.

Anguilla. The four cases of leprosy which existed before 1897 are still here. These four lepers ase suffering from anaesthetic leprosy. They are between 50 and 60 years of age and have been suffering from leprosy from 30 to 40 years. Their leprosy is of the anaesthetic kind.

There are other persons — not more than six at the most — who have some suspicious symptoms but none of these can be definetely called lepers.

Do.	M.	F.
from 5 to 10 years of age	4	3
„ 10 to 20 „ „ „	42	26
„ 20 to 40	75	31
„ 40 upwards	113	27
	Total 321	

Occupations of Do.	M.	F.
Labourers	153	33
Gardeners	2	2 cooks.
Servants (Groom, Butler etc.)	2	3
Painter	1	1 Cakeseller.
Cart drivers	3	2 Hucksters.
Fisherman	1	3 Seamstresses.
Clerks	2	4 Laundresses.
Carpenters	3	—
Nil	67	39
	Total 321	

Nationality	M.	F.
Trinidad or West Indies	99	67
India	126	13
Portuguese	5	3
		3 Venezuela.
Africa	4	1
	Total 321	

Record of Cases at Leper Asylum bearing on question of Heredity, etc.

1. G. O'B. — Male. 40. Trinidad. Black. Anaesthetic, many years - alive. not in Asylum.
2. Married. H—a tuberculated woman. 36. Trinidad. Black 3 children.
3. 1° A Girl, 12. Anaesthetic; in Asylum.
4. 2° A Girl, 9. Anaesthetic; in Asylum.
5. 3° A Girl — died at the age of 4 months in the Orphanage „of an eruption".
   The mother (2) died in the Asylum a few months after.
6. B--l—d: Mal 36. Trinidad: Coloured; anaesthetic.
7. B-l--d. Female 16. Trinidad. White. Anaesthetic.
   6 and 7 same Father.
   Different Mothers.
   Father dead — cause unknown.
   Mother of 6 dead — cause „a cold".
   Mother of 7 alive and well.
8. E -V. Male 45. Trinidad. Tuberculated — in Asylum.

9. R. V. Brother of (8) died in Asylum. Tubercular.
10. J. V. Sister of (8) in Asylum. Tubercular.
11. W—N. A nephew of (8) in Asylum. Tuberculated.
 8. 9. 10. Same Father.
 Different Mothers
 History of Father not procurable.
12. E—R. Female. Trinidad. Tubercular. In Asylum.
 Father died of T. L. in Asylum some years ago.
13. N—S. Male. 12. In Asylum. Tubercular.
 Father died of T. L.
14. „Leo". Male. 14. Mother died of leprosy when Leo was at the breast.
15. T—. Male. 12. A cousin of (14) on the mother's side. In Asylum. Tuberculated.

It will be observed that the total number of patients in the institution onthe 31st of December 1903 was 321. It is probable that enough more are at large to make the whole number of lepers in the Colony up to 500; this in a population estimated to be slightly in in excess of 300 000.

The males outnumber the females in the proportion of nearly three to one.

With regard to age, the incidence increases steadily from early childhood up to 40 and over.

The disease occurs almost exclusively amongst the humbler classes, the great majority being labourers.

With respect to Nationality, India furnishes the greater proportion (and Dr. de Wolff adds that East Indians and their descendants born in the Colony constitute one third of the population.) The disease is extremely rare amongst white persons.

The means taken to deal with the disease, both before and since the International Leprosy Conference of 1897, have been, Segregation and Isolation. While no law of general compulsory segregation exists, yet every encouragement is given to induce those suffering from the disease to enter the Asylum, and of late years, Ordinances have been passed to authorize the arrest and detention of vagrant lepers, (ordinance: 24 of 1898 Sec. 13), and to prohibit lepers from engaging in occupations connected with the preparation of food, clothing &c. (Ordinance: 18 of 1901).

Bahamas.

Mr. J. Baird Albury, Surgeon, writing for Dr. J. Benson Albury, Medical Inspector and President of the Board of Health, has sent me the following: All dàta relative to Leprosy in the Bahamas are very imperfect for the following reasons. The Bahamas consists of a group of about 40 islands only five of which have medical men on them, therefore in most cases Government reports on this subject, have been gathered together by resident Justices more or less ignorant of medical matters and their opinions unconfirmed by medical diagnosis.

In 1890 there were 62 lepers reported in response to a Government enquiry. In 1899 the number of cases was again 62, 28 of whom

were reported in 1890 (the rest having since died) and 34 of whom were fresh cases. There has been no report since 1899, but Mr. Albury is convinced that at the present time, there is a much greater number than these reports lead one to expect. The cases are widely distributed. the greatest number being at Inagua and Watling's Island (10 each). Many islands have no cases at all.

There is small leper ward at the New Providence Asylum open to any voluntary lepers and accommodating about 10, they are not strictly isolated and receive proper medical attendance. He believes Chaulmoogra oil is much used there, but without any definite satisfactory results. The great mass of the lepers are quite at liberty to live as it pleases them, some voluntarily live apart, others freely mingle with the people. Most have no treatment at all, a few indulge in bitters but in all the progress is steadily downwards to a fatal termination.

Grenada.

Mr. Edward Drayton, Colonial Secretary to the Government of Grenada, writes to say: that all the information at the disposal of the Government in this connexion is that contained in the Returns of the Census taken in 1901, which show 20 lepers (13 males and 7 females) at 7th April, 1901, in the colony. No special steps are taken to prevent the spread of the disease.

British Guiana (10).

I am indebted to Dr. J. E. Godfrey, Acting Surgeon General, for a copy of the Surgeon General's Report for 1902—03, from which I take the following remarks by Dr. F. A. Neal. the Medical Superintendent of the Public Leper Asylum, Mahaica.

As far as possible, the inmates are not allowed to lead an idle life. They perform all the necessary work of the institution under the supervision of the attendant staff, which in consequence is not so large as it otherwise would have to be.

Schools have been kept regularly for the younger members.

The Grounds were kept up, and the Farm gave a good return.

The accommodation was sufficient for present needs, but unfortunately the numbers have been increasing, and should this continue additional buildings will be required, and at no distant date.

Statistics. -- Remaining on 1st April 1902:

312 Males	96 Females	Total 408.

Admitted during the year:

72 Males	13 Females	Total 85.

This includes a boy and girl who were not diseased.

The number re-admitted was:

20 Males	2 Females	Totat 22.

The discharges numbered:

28 Males	1 Female	Total 29.

The female discharged was not a leper, and of the remaining names struck off no less than 19 coolies and 5 blacks were new comers.

The number of deaths was:

41 Males 11 Female Total 52.

As usual, symptoms of a dysenteric nature, a „terminal dysentery" often supervene at the end, cases resembling Sprue or Psilosis Linguae are not infrequently seen amongst the inmates. Mention is made of Sprue as the disease is not common in the Colony, at any rate it is doubtful if its occurrence has been previously noted.

The percentage of deaths was:

9,4 Males 9,9 Females Total 9,5.

Remaining on the 31st March 1903:

335 Males 99 Females Total 434.

The daily average was:

326 Males 95 Females Total 421.

The numbers, especially of males, heve been steadily going up. There is no cause of alarm, as fortunately it is not due to any increase in the admission rate, but is mainly the result of a diminished wastage. Since 1897 no East Indian lepers from the Asylum have been repatriated; the death-rate for years has been considerably lower; and inmates after a residence in the Asylum now seem to prefer the conditions here to a precarious existence outside, and so do not leave in such numbers.

The statistics for the year are set out in the subjoined table. It shows the numbers for each of the different races, and the East Indians divided into immigrants proper and coolies born in the Colony.

	Natives		Islanders		Africans		East Indians		Creole Coolies		Chinese		Portuguese		Children		Total		Grand Total
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
naing 1st April, 1902	113	64	17	5	6	2	140	11	26	5	5	2	5	7	—	—	312	96	408
nitted,																			
pers, 1902–1903 . .	19	5	2	—	—	—	45	5	3	1	1	—	1	1	—	—	71	12	83
n-Lepers, 1002–1903	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	—	1	1	2
dmitted	2	—	1	—	—	—	13	2	2	—	—	—	2	—	—	—	20	2	22
sults	134	69	20	5	6	2	198	18	31	7	6	2	8	8	1	—	404	111	515
charged, Non Lepers	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1	1
„ Lunatic Asylum	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	1
charged, Absconding .	6	—	1	—	—	—	17	—	2	—	—	—	1	—	—	—	27	—	27
d	9	6	1	1	1	1	21	2	3	1	2	—	—	—	1	—	38	11	49
owned	—	—	—	—	—	—	1	—	—	—	1	—	—	—	—	—	2	—	2
nging	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	1
maing 31st March, 1903	119	63	18	4	5	1	157	16	26	5	2	2	7	8	—	—	335	99	434

The Antipodes.

Australia and Tasmania.

This area will be reported on separately by Dr. Ashburton Thompson, as I have already stated. I take this opportunity of thanking the following gentlemen for their kind replies to my circular letter: Mr. J. W. Colville, Secretary to the Public Health Department, Melbourne; Dr. J. S. C. Elkington, Chief Health Officer for Tasmania; Dr. Ramsay Smith, Chairman of the Central Board of Health. Adelaide, and Dr. W. L. Cleland of the same City.

New Zealand (Including the Cook Islands).

I am indebted to Dr. J. M. Mason. Chief Health Officer of Health of the Colony for this note concerning leprosy in New Zealand. With the exception of the settlement at Molokai (Penrhyn), the usual plan is adopted. If the patient has surface lesions likely to cause the spread of the disease he is segregated, but where from the symptoms it appears that there is little or no danger of infection, the patient is allowed to remain in his own home. There are no cases among the white population of New Zealand. As to transport by rail etc., in the few instances where the patients have had to be moved the carriages have been simply disinfected after use.

There are five known cases of leprosy in New Zealand, one of them being a Chinaman.

At Molokai, which is situated upon one part of the atoll Penrhyn and which has been set apart by te natives on their own initiative for the segregation of all persons suffering from leprosy, there are 10 patients, seven of these are females and 3 males.

Fiji.

Dr. B. Glanvill Corney, the Chief Medical Officer, has supplied the following particulars regarding the action taken in Fiji and the islands within the High Commissionership of Western Polynesia, in connection with leprosy and its incidence here, since the session of the International Leprosy Congress at Berlin in 1897.

Dr. Corney had already, before that date, made a series of journeys in the large island of Viti Levu on purpose to ascertain the degree in which leprosy prevailed, and in several of the smaller islands and clusters of islets near to it. These journeys resulted in his meeting with and examining rather more than 400 cases among the aboriginal Fijians, in various stages of development; and about 20 others in Indian coolies.

On this, in 1892, steps were taken to improve the quality of the isolation which had for years been prescribed for the Fijian lepers on the outskirts of their native villages, and to minimize the hardships incident to their separation from their families and food gardens. But a special segregation camp, situated a quarter of mile from the Colonial Hospital and administered by the medical and nursing staff of that institution, was made use of for the accomodation, sustenance, and treatment of all vagrant or indigent lepers who might voluntarily seek

its hospitality. These numbered usually about 12 or 13, most of whom were Indians, a few Melanesian immigrants from the Solomon Islands, and now and again a Fijian prisoner. There was also one white man, born in Fiji of European parents.

In 1892, also, Dr. Corney drafted a Bill to legalise measures for restraining the spread of leprosy and for making provision for the care and detention of lepers in certain circumstances; but various occurrences hindered its being brought before the Legislative Council; and it was not until a new Governor had resided some two years in the Colony that a Lepers' Ordinance was finally passed. This was Ordinance No. VII of 1899, admittedly an imperfect enactment, and one which falls very far short of measures which Dr. Corney and his medical colleagues considered would be justifiable, and adequate to the real ends in view. But His Excellency announced that the Colonial Office authorities were not at that time prepared to approve any more comprehensive plan, nor any more stringent measures, in the direction of compulsory segregation; and the Ordinance as drafted, with trifling amendments introduced in Council, was therefore adopted. It was based on a similar one enacted in the Straits Settlements, where the social circumstances of the people differ widely from those obtaining in Fiji.

The Ordinance (see Appendix IV) which only acquires the force of law on being proclaimed in any particular area or areas by the Governor (four such areas have been proclaimed), empowers the Governor to establish Leper Asylums, and to appoint officers for their administration and inspection. It provides for the committal by a magistrate of leprous persons who offend in certain particulars against its provisions, to any of such Asylums.

It prohibits lepers from following certain trades and occupations connected with the production, preparation, sale or distribution of articles intended to be used as human food, or drink, or as medicine; or with tobacco or wearing apparel. It forbids them to serve as domestic attendants, barbers, attendants on the sick, midvives, hawkers, laundrymen, cooks, or hackney carriage drivers.

It provides also for the relegation of vagrant lepers to an Asylum, for the transfer of any leprous prisoner from a Gaol, or leprous patient from a Lunatic Asylum, to a Leper Asylum.

It prohibits all lepers not born in the Colonies from disembarking in it, under pain of detention in an Asylum; and imposes a penalty (not exceeding £ 100) on the master of any vessel if he knowingly suffers such a leper to disembark.

Section 14 authorizes the detention of lepers committed to Asylums, and their recapture in case of absconding.

Section 16 empowers the Governor in Council to make regulations for the management, inspection, and control of Leper Asylums; and for various other matters with which the Ordinance deals. Such Rules, a copy of which is also appended to this memorandum, were enacted in September 1901. In the preparation and drafting of these Rules Dr. Corney took into consideration much of the evidence brought forward at the Berlin Congress. The Rules were duly approved by the Legislative Council and became law.

About the same time it was thought expedient, in view of the possible increase in the number of lepers to be segregated and cared for, and of the too great proximity of the existing camp to the town of Suva, to set apart a suitable site as a Leper Asylum under the provisions of the new law, somewhat farther afield. To this end he examined several islands and possible sites, and finally selected a convenient isolated peninsula on the island of Bega, 23 miles from Suva, by sea, as the crow flies, and 7 miles from the nearest part of the coast of the main island of Viti Levu. It is accessible by steamer or cutter for purposes of administration of inspection and inspection, but quite out of the range of casual wanderers (especially of coolies); and is bounded on three sides by deep water, with a mountain skirting the fourth.

This site, known as Malumu, was then surveyed and proclaimed an area under the Lepers' Ordinance, and appointed by the Governor a Leper Asylum (Nov. 1901) and has been occupied as such ever since.

The average number of patients in detention has, however, not materially increased. A few have died, and a few others voluntarily come in. They number at present 14 Indians and Melanesians, and one white youth transferred from the former camp near Suva.

The Asylum is under the care of a resident native warder and an assistant warder: the local Native Practitioner attends every two weeks to see patients, and in emergencies. The European District Medical Officer pays a visit once a month to direct the work of the warders, attend to complaints and disputes, and treat the patients. A half yearly inspection is made on behalf of the Government by the Chief Medical Officer of the Colony, who reports to the Governor.

Owing to absence in Europe, and other circumstances, Dr. Corney could not supply exact statistical information, but he had not been able to learn that any noticeable increase or decrease in the number of cases through the country had taken place of late years, beyond a certain number of Indian cases proportionate to the increase of the total coolie population brought about by immigration from India.

Of the outside islands under the jurisdiction of the High Commissioner for Western Polynesia he knows practically nothing regarding the incidence of leprosy.

Conclusions.

Reviewing the foregoing survey, one feature stands out prominently, viz: the enormous mass of leprosy with which the British have to cope. The magnitude of the task needs no emphasizing when we consider the number and variety of the native races, the hugeness of the population, the vastness of the area under the sway of the English.

As far as leprosy is concerneda large amount of work has been done since 1889 to prevent the spread of the disease and alleviate the sufferings of the unfortunate victims, a result which has ceen achieved greatly owing to the initiative of King Edward VII, who when Prince of Wales, started the National Leprosy Fund as a tribute to the self-sacrifice of Father Damien.

In 1897, the Leprosy Conference held in Berlin under the auspices

of the Prussian Government gave a further impetus to the struggle against leprosy by insisting on the contagiousness of the complaint.

I propose to touch briefly in this place on the effects which followed in the wake of the Berlin Congress.

In India, Lepers Act No. 111 (1898) was passed, and subsequently extended to Assam (1902), in which province an Asylum, Sylhet (1902), was established; to Burma, except the Shan States and four leper asylums established (1902—1903); to Bengal, in which presidency two institutions were declared leper asylums for purposes of the Act and also to several districts of the United Provinces. Sections of the Act have also been applied to the Central Provinces and Asylums arranged for (1898—1903) to carry them out. On the other hand the Madras and Bombay Presidencies, and the Punjab, have not adopted it, but it should be noted that in both the Bombay and Madras areas Leper Asylums are available. As to the Punjab, the want of Asylum accommodation stands in the way. The Native States generally have not adopted the Act. In these instances, it cannot be doubted but that more active measures will be taken in time.

I cannot leave India without calling attention to the communication of Dr. Rost.

In Ceylon, the recommendations of the Berlin Conference resulted in the Leper Ordinance No. IV, of 1901, which deals with the segregation of certain lepers.

In Mauritius, the government was urged to introduce a law to provide for the isolation of Asylum patients as a means of confirming the evil within limits. But up to the present no effect has been given to these representations.

Turning to Africa, proposed legislation in the matter is under consideration in Southern Nigeria.

As to the Colonies in America, a paragraph was introduced into the Quarantine regulations of the Dominion of Canada (1898) to the effect that any person found suffering from leprosy was not to be allowed to land and was to be taken back by the vessel to the place whence the leper came.

In Jamaica there is a diminution in the number of lepers, as a result apparently of a more vigorous enforcing of Law 15 of 1896.

A Bill is before the Legislature of Barbados to prohibit the landing of lepers and also to prevent lepers engaging in any trade or occupation, and entering any hotel or vehicle.

Dr. Nicholls of Dominica insists on the danger of letting loose the lepers segregated in those West Indian Islands where the disease prevails.

In Trinidad, Ordinance XXIV (1898) authorizes the detention of vagrant lepers and Ordinance XVIII (1901) prohibite lepers from engaging in occupationsfor preparing food, etc.

Harking now to far Fiji, Ordinance No. VII (1899) dealing with lepers is also a direct outcome of the Berlin Conference.

It will be seen therefore that the deliberations of 1897 have not been in vain for they stimulated to fresh efforts in a struggle, to say the least of it, discouraging because of its difficulties and of its apparent hopelessness.

The part played by the immigration of individuals in numbers (Chinese and Indian coolies) from leprous foci in the spread of the disease is brought out in several passages of this report. It is a point which calls for vigilance on the part of responsible administrators.

An important matter again, now that the hereditary theory of leprosy has been knocked on the head, is the successful separation of children from their leprous parents, thus eliminating a further source of increase in the incidence of the disease.

„The Times" thought fit a short time ago to take the fish theory under its wing. That explains, no doubt, the many references to it in the material sent me. Although the fish theory was not mentioned in the request for information, quite a number of correspondents touched upon it, but only to reject it as not having a leg to stand on. As to the alleged great prevalence of leprosy among the native Roman Catholics in Chota Nagpur, the Reverend Ferdinand Hahn, Superintendent of the Purulia Leper Asylum, and Secretary to the German Evangelical Lutheran Mission, Chota Nagpur, states that, among the Roman Catholic converts there, whose number is about 60000, there are scarcely a dozen lepers and all these were lepers before they embraced Christianity. In this connexion, supposing there were more lepers among the Roman Catholic native converts, I would point out that, in my experience, in the Sandwich Islands for instance, it is among the poorest and therefore among those most likely to suffer from leprosy that the Roman Catholics work.

I take this opportunity of expressing my great indebtedness and my sincere thanks to all those in many parts of the world, who have supplied me with information.

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Appendix No. I.

India. Act no. III of 1898.

Passed by the Governor General of India in Council. — Received the assent of the Governor General on the 4th February, 1898.

An Act to provide for the segregation and medical treatment of pauper lepers and the control of lepers following certain callings.

Whereas it is expedient to provide for the segregation and medical treatment of pauper lepers and the control of lepers following certain callings; It is hereby enacted as follows:

I. 1. This Act may be called the Lepers Act, 1898.

2. It extends to the whole of British India, inclusive of Upper Burma, British Baluchistan, the Santal Parganas and the Pargana of Spiti; but

3. It shall not come into force in any part thereof until the Local Government, as hereinafter provided, has declared it applicable thereto.

4. The Local Government may, by notification in the official Gazette, apply this Act or any part thereof to the whole or any portion of the territories for the time being under its administration, and may in like manner amend or cancel any such notification.

II. In this Act, unless there is anything repugnant in the subject or context,—

I. „Leper“ means any person suffering from any variety of leprosy in whom the process of ulceration has commenced;

2. „Pauper" leper means a leper—

a) who publicly solicits alms or exposes or exhibits any sores, wounds, bodily ailment or deformity with the object of exciting charity or of obtaining alms, or

b) who is at large without any ostensible means of subsistence;

3. „Leper asylum" means a leper asylum appointed under section 3;

4. „Board" means a Board constituted under section 5; and

5. „District Magistrate" includes a Chief Presidency Magistrate.

III. The Local Government may, by notification in the official Gazette, appoint any place to be a lepor asylum for the purposes of this Act and specify the local areas from which lepers may be sent to such asylum, and may, in like manner, alter or cancel any such notification.

IV. Subject to any rules which may be made under section 16, the Local Government may appoint any Medical Officer of the Government or other qualified medical man to be an Inspector of Lepers and any person to be a Superintendent of a Leper Asylum, with such establishment as may, in its opinion, be necessary, and every Inspector or Superintendent so appointed shall be deemed to be a public servant.

V. The Local Government shall constitute for every leper asylum appointed under section 3 a Board consisting of not less than three members, one of whom at least shall be a Medical Officer of the Government.

VI. 1. Within any local area which has been specified under section 3 any police-officer may arrest without a warrant any person who appears to him to be a pauper leper.

2. Such police-officer shall forthwith take or send the person so arrested to the nearest convenient police-station.

VII. Every person brought to a police-station under the last foregoing section hall, without unnecessary delay, be taken before an Inspector of Lepers, who,—

a) if he finds that such person is not a leper within the meaning of section II, shall give him a certificate in Form (A) set forth in the schedule, whereupon such person shall be forthwith released from arrest;

b) if he finds that such person is a leper within the meaning of section 2, shall give to the police-officer, in whose custody the leper is, a certificate in Form (B) set forth in the schedule, whereupon the leper shall, without unnecessary delay, be taken before a Magistrate having jurisdiction under this Act.

VIII. 1. If it appears to any Presidency or Magistrate of the first class or to any other Magistrate authorised in this behalf by the Local Government, upon the certificate in Form (B) set forth in the schedule, that any person is a leper, and if it further appears to the Magistrate that the person is a pauper leper, he may, after recording the evidence on the above-mentioned points, and his order thereon, send the pauper leper in charge of a police-officer, together with an order in Form (C) set forth in the schedule, to a leper asylum, where such leper shall be detained until discharged by order of the Board or the District Magistrate:

Provided that, if the person denies the allegation of leprosy, the Magistrate shall call and examine the Inspector of Lepers, and shall take such further evidence as may be necessary to support or to rebut the allegation that the person is a leper, and may for this purpose adjourn the enquiry from time to time, remanding the person for observation or for other reason to such place as may be convenient, or admitting him to bail:

Provided also that if any friend or relative of any person found to be a pauper leper shall undertake in writing to the satisfaction of the Magistrate that such pauper leper shall be properly laken care of and shall be prevented from publicly begging in any area specified under section 3, the Magistrate, instead of sending the leper to an asylum, may make the leper over to the care of such friend or relative, requiring him, if he thinks fit, to enter into a bond with one or more suretis, to which the provisions of section 514 of the Code of Criminal Procedure shall be applicable.

2. If the Magistrate finds that such person is not a leper, or that, if a leper, he is not a pauper leper, he shall forthwith discharge him.

IX. 1. The Local Government may, by notification in the official Gazette, order that no leper shall, within any area specified under section 3,—

a) personally prepare for sale or sell any article of food or drink or any drugs or clothing intended for human use; or

b) Bathe, wash clothes or take water from any public well or tank debarred by any municipal or local bye-law from use by lepers; or

c) drive, conduct or ride in any public carriage plying for hire other than a railway carriage; or

d) exercise any trade or calling which may by such notification be prohibited to lepers.

2. Any such notification may comprise all or any of the above prohibitions.

3. Whoever disobeys any order made pursuant to the powers confered by this section shall be punishable with fine which may extend to twenty rupees:

Provided that, when any person is accused of an offence under this section, the Magistrate before whom he is accused shall cause him to be examined by an Inspector of Lepers, and shall not proceed with the case unless such Inspector furnishes a certificate, in Form (B) set forth in the schedule, in respect of such person.

X. 1. Whenever any leper who has been convicted of an offence punishable under the last foregoing section is again convicted of any offence punishable under that section, the Magistrate may, in addition to, or in lieu of, any punishment to which such leper may be liable, require him to enter into a bond, with one or more sureties, biding him to depart forthwith from the local area specified under section 3 in which he is, and not to enter that or any other local area so specified until an Inspector of Lepers shall have given him a certificate in Form (A) set forth in the schedule.

2. If any such leper fails to furnish any security required under subsection 1, the Magistrate may send him in charge of a police-officer, with an order in Form (D) set forth in the schedule, to a leper asylum, where such leper shall be detained until discharged by order of the Board or the District Magistrate.

3. The powers conferred by this section shall only be exercised by a Presidency Magistrate or Magistrate of the first class.

XI. Any person who, within any area specified under section 3, knowingly employs a leper in any trade or calling prohibited by order under section IX shall be punishable with fine which may extend to fifty rupees:

Provided that the alleged leper shall be produced before the Magistrate and the Magistrate shall cause him to be examined by an Inspector of Lepers, and shall not proceed with the case unless such Inspector furnishes a certificate in Form (B) set forth in the schedule in respect of such alleged leper.

XII. Whoever, having been sent to a leper asylum under an order of a Magistrate in Form (C) or Form (D) set forth in the schedule, escapes from, or leaves, the asylum without the permission in writing of the Superintendent thereof, may be arrested by any police-officr without a warrant, and upon arrest shall be forthwith taken back to the leper asylum.

XIII. Two or more members of the Board, one of whom shall be the Medical Officer, shall, once at least in every three months, together inspect the leper asylum which they are constituted, and ses and examine

a) every leper therein admitted since the last inspection, together with the order for his admission, and

b) as far as circumstances will permit, every other leper therein, and shall enter in a book to be kept for the purpose any remarks which they may deem proper in regard to the management and condition of the asylum and the lepers therein.

XIV. Any two members of the Board, one of whom shall be the Medical Officer, may at any time, by an order in writing in Form (E) set forth in the schedule and signed by them, direct the discharge from the leper asylum of any leper detained therein under the provisions of this Act.

XV. Any person, other than a pauper leper, in respect of whom an Inspector of Lepers has issued a certificate, in Form (B) set forth in the schedule, declaring him to be a leper, or has refused to issue a certificate in Form (A) set forth in the schedule, may appeal against the issue or refusal of any such certificate to such officer as may be appointed by the Local Government in this behalf, and the decision of such officer shall be final.

XVI. The Local Government may, by notification in the official Gazette, make rulos generally for carrying out the purposes of this Act, and in particular—

a) for the guidance of all or any of the officers discharging any duty under this Act; and

b) for the management of, and the maintenance of discipline in, a leper asylum.

XVII. Notwithstanding anything in any enactment with respect to the purposes to which the funds or other property of a local authority may be applied, any local authority may—

a) establish or maintain, or establish and maintain, or contribute towards the cost ot the establishment or maintenance or the establishment and maintenance of, a leper asylum either within or without the local limits of such local authority;

b) with the previous sanction of the Local Government and subject to such conditions as that Government may prescribe, appropriate any immoveable property vested in, or under the control of, such body, as a site for, or for use as, a leper asylum.

XVIII. No suit, prosecution or other legal proceeding shall lie against any officer or person in respect of anything in good faith done or intended to be done under, or in pursuance of, the provisions of this Act.

XIX. When any part oft this Act has been applied unter sub-section 4. of section I to the wohle or any portion of the territories administered by the Lieutenant-Governor of Bengal, the Lieutenant-Governor may, by notification in the official Gazette, direct that the whole or any part of the Lepers Act, 1895, shall, except as regards anything done or any offence committed or any fine or penalty incurred or any proceedings commenced, cease to have effect in the portion of the said territories to which this Act has been so applied.

SCHEDULE.

(A)—Certificate.

(Section 7.)

I, the undersigned *(here enter name and official designation)*, hereby certify that I on the day of at personally examined *(here enter name of person examined)* and that the said is not a leper as defined by the Lepers Act, 1898.

Given under my hand this day of 189

(Signature.)
Inspector of Lepers.

(B)—Certificate.

(Section 7.)

I, the undersigned *(here enter name and official designation)*, hereby certify that I on the day of at personally examined *(here enter name of leper)*, and that the said is a leper as defined by the Lepers Act, 1898, and that I have formed this opinion on the following grounds, namely,—

(Here state the grounds.)

Given under my hand this day of 189 .

(Signature.)
Inspector of Lepers.

(C)—Warrant of Detention.

(Section 8.)

To the Superintendent of the Leper Asylum at

Whereas it has been made to appear to me that *(name and description)* is a pauper leper as defined in the Lepers Act, 1898;

This is to authorize you, the said Superintendent, to receive the said into your custody together with this order and $\frac{\text{him}}{\text{her}}$ safely to keep in the said asylum until $\frac{\text{he}}{\text{she}}$ shall be discharged by order of the Board or the District Magistrate.

Given under my hand and the seal of the Court this day of 189 .

(Seal.) *(Signature.)*
Magistrate.

(D)—Warrant of Detention.

(Section 10.)

To the Superintendent of the Leper Asylum at

Whereas *(name and description)* has this day been convicted by me of an offence punishable under section 9 of the Lepers Act, 1898, and whereas it has been proved before me that the said *(name and description)* was previously convicted of an offence punishable under the same section:

This is to authorize you, the said Superintendent, to receive the said into your custody together with this order and $\frac{\text{him}}{\text{her}}$ safely to keep in the said asylum until $\frac{\text{he}}{\text{she}}$ shall be discharged by order of the Board or the District Magistrate.

Given under my hand and the seal of the Court this
day of 189 .

(Seal.) *(Signature.)*
Magistrate.

(E)—Order of Discharge by Board.[1])

(Section 14.)

To the Superintendent of the Leger Asylum at

Whereas (*name and description*) was committed to your custody under an order dated the day of 189
and there have appeared to us sufficient grounds for the opinion that $\frac{\text{he}}{\text{she}}$ can be released without hazard or inconvenience to the community;

This is to authorize and require you forthwith to discharge the said (*name*) from your custody.

Given under our hands this day of 189 .

(Signatures.)
Members of theAsylum Board.

Appendix No. II.

India. Act No. XIII of 1903.

Passed by the Governor General of India in Council.
(Received the assent of the Governor General on the 18th September, 1903.)

An Act further to amend the Lepers Act, 1898. III of 1898.

Whereas it is expedient further tho amend the Lepers Act, 1898, by providing for the segregation and medical treatment in British India of lepers belonging to Native States; It is hereby enacted as follows:

Short title.

1. This Act may be called the Lepers (Amendment) Act, 1903.

Addition of new section after Section 18, Act III 1898. III of 1808.

2. After Section 18, of the Lepers Act, 1898, the following section shall be added, namely:

Lepers from Native States.

„19. The Governor General in Council may, by notification in the Gazette of India, direct that any leper or class of lepers, with respect to whom an order for segregation and medical treatment has been made by a Magistrate having jurisdiction within the territories of any Native Prince or State in India, may be sent to any leper-asylum specified in such order; and thereupon the provisions of this Act and of any rules made thereunder shall, with such modifications not affecting the substance as may be reasonable and necessary to adapt them to the subject-matter, apply to any leper sent to a leper asylum in pursuance of such notification as though he had been sent by the order of a Magistrate having jurisdiction under this Act."

1) A corresponding form may be used by the District Magistrate for orders of discharge issued under section X. 2.

Appendix No. III.

Ceylon.

Ordinance enacted by the Governor of Ceylon, with the advice and consent of the Legislative Council thereof.

No. 4 of 1901.

An Ordinance to provide for the segregation and treatment of Lepers.

West Ridgeway.

Whereas the disease of leprosy is prevalent in this island, and it is expedient to provide for the segregation and treatment of lepers: Be it therefore enacted by the Governor of Ceylon, by and with the advice and consent of the Legislative Council thereof, as follows:

1. This Ordinance may be cited as „The Lepers' Ordinance, 1901," and shall come into operation on such date as the Governor shall, by Proclamation to be published in the Government Gazette, appoint.

2. It shall be lawful for the Governor, with the advice of the Executive Council, from time to time to appoint any such place as he shall think fit to be a leper asylum for the segregation and treatment of lepers; and every such leper asylum shall comprise such area as the Governor shall from time to time define by Proclamation published in the Government Gazette.

3. The place now and heretofore known as the leper hospital or asylum, situate at Hendala, shall be deemed to be a leper asylum established under the provisions of this Ordinance, and all acts heretofore done and suffered with regard to lepers and the segregation, support, and treatment of lepers in the said leper hospital or asylum shall be deemed to have been done and suffered in accordance with law.

4. Any person detained as a leper in a leper asylum may by the special permission of the Governor erect or cause to be erected for himself a dwelling-house at his own proper expense within the limits of the leper asylum in which he is detained, subject to such conditions as to plan, site, drainage, and otherwise as to the Governor shall seem fit.

5. It shall be the duty of every person having knowledge of the existence of a leper or a person reasonably suspected of being a leper in any place outside the limits of any leper asylum to give information thereof to the Government medical officer residing nearest to the village or place in which such leper or suspected leper resides or is found, and such medical officer shall forthwith report the same to the Principal Civil Medical Officer.

6. Every person wilfully neglecting to give such information as aforesaid, and every medical officer wilfully neglecting to report the same as aforesaid, shall be guilty of an offence, and shall be liable on conviction for each such offence to a fine not exceeding fifty rupees.

7. On the receipt of such report as aforesaid the Principal Civil Medical Officer shall forthwith forward such report to the Colonial Secretary for the information of the Governor, and such inspection and examination of the alleged leper shall be held and such report made thereon as the Governor shall order or as shall be from time o time prescribed by such general regulations in that behalf as shall from time to time be made under section 13 of this Ordinance.

8. After such inspection, examination, and report as aforesaid, it shall be lawful for the Governor, if he shall think fit, to order the leper or alleged leper to be removed to and detained in a leper asylum. Provided always that no person shall be removed to or detained in a leper asylum unless a certificate shall have been given by two qualified medical practitioners, one of whom shall be the Principal Civil Medical Officer of the Island, that such person is actually suffering from the disease of leprosy.

9. (1) No such order for removal or detention as in the next preceding section mentioned shall be made if the leper or alleged leper shall in the opinion of the Governor be able to provide for himself at his own place of abode effective isolation and medical treatment, and shall within the time prescribed by the Governor carry out such directions as the Governor may give for securing such isolation, but in every such case it shall be lawful for the Governor from time to time to prescribe rules for observance by such leper or alleged leper in order to secure such isolation.

(2) In the event of the disregard or breach of any such rules the Governor may under section 8 order such leper or alleged leper to be removed to and detained in a leper asylum.

10. No person detained as a leper in a leper asylum shall leave the asylum without the permission in writing of the Principal Civil Medical Officer, or in his absence the Assistant Principal Civil Medical Officer, and every person acting in contravention of this section shall be guilty of an offence, and shall be liable on conviction for each such offence to simple imprisonment for a therm which may extend to three months.

11. Every person found within the limits of a leper asylum without the written permission of the Principal Civil Medical Officer or without lawful authority shall be guilty of an offence and shall be liable on conviction for each such offence to a fine not exceeding fifty rupees.

12. The Principal Civil Medical Officer shall have and exercise all the powers of a police magistrate with respect to all offences committed by persons detained as lepers in a leper asylum, and shall also have power to hear and determine all complaints of offences punishable under section 10 of this Ordinance. And it shall be lawful for the Governor from time to time to appoint any medical officer having charge of any leper asylum to have and exercise all the powers of a police magistrate therein. Every decision given under the provisions of this section shall be subject to the same rights of appeal as the decisions of a police magistrate.

13. It shall be lawful for the Governor, with the advice of the Executive Council, from time to time to make such regulations as he may deem necessary —

a) For inspection, examination, and removal of lepers to a leper asylum;
b) For the proper management and sanitation of the leper asylum or asylums;
c) For the discipline and good order of the inmates of such asylum or asylums;
d) For the custody and imprisonment within such asylum or asylums of lepers accused of and found guilty of offences;
e) For regulating the sittings and procedure of courts to be held under the provisions of this Ordinance;
f) Generally for the better carrying out of the provisions of this Ordinance and for the well being of such asylum or asylums and the inmates thereof;

and from time to time to revoke, amend, and vary such regulations.

All regulations made under the provisions of this section shall be published in the Government Gazette, and from the date of such publication shall have the same force and effect as if they were enacted in and formed part of this Ordinance;

and every person acting in contravention of any regulation made under the provisions of this section shall be guilty of an offence, and shall be liable on conviction for each such offence to a fine not exceeding fifty rupees, or to imprisonment for any term not exceeding one month.

Passed in Council the Twenty-first day of February, One thousand Nine hundred and One.

A. G. Clayton.
Clerk te the Council.

Assented to by His Excellency the Governor the Twenty-eighth day of February, One thousand Nine hundred and One.

W. T. Taylor,
Acting Colonial Secretary.

Appendix No. IV.

Fiji. No. VII, 1899.

An Ordinance

(Enacted by the Governor of the Colony of Fiji with the advice and consent of the Legislative Council thereof).

Relating to Lepers.

[L.S.] G. T. M. O'Brien.

18th July, 1899.

Be it enacted by the Governor with the advice and consent of the Legislative Council as follows:—

1. This Ordinance may be cited as „The Lepers Ordinance 1899".

2. In this Ordinance—

„Leper" shall mean a person who is the subject of any form of the disease known as Leprosy or *lepra vera.*

„Qualified Medical Practitioner" shall mean a person entitled by the law in force for the time being to practise in this Colony as a physician or surgeon.

3. The Governor in Council may from time to time by notification published in the *Royal Gazette* prohibit the carrying on by a Leper of any of the trades or callings specified in the Schedule hereto.

4. (1) Any Leper carrying on any trade or calling so prohibited as aforesaid or taking any part therein and any person who shall knowingly employ a Leper in any such trade or calling shall be liable upon summary conviction to a fine not exceeding five pounds or to imprisonment with or without hard labour not exceeding one month or to both and any Leper so convicted may be commited to a leper asylum to be detained there until discharged by order of the Governor.

(2) Any Leper who shall enter any hackney-carriage or other public vehicle or lodge in any hotel boarding-house or lodging-house or bathe in any public bath shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding five pounds and may be committed to a leper asylum to be detained there until discharged by order of the Governor.

(3) Any Leper convicted a second time under either of the above subsections shall in addition to any other penalty be committed to a leper asylum to be detained there until discharged by order of the Governor.

5. The Governor may establish Leper Asylums at such places as he may think

proper for the reception and detention of Lepers and may declare any place heretofore used for the treatment and segregation of Lepers to be a Leper Asylum within the meaning of this Ordinance and shall appoint a fit and proper person to be the officer in charge of each such asylum.

6. Whenever any person is summarily convicted of vagrancy and the convicting magistrate is satisfied that the person so convicted is a Leper it shall be lawful for such magistrate by warrant under his hand to order the detention of such Leper in a leper asylum until he is discharged by order of the Governor and upon a second conviction under this section the convicting magistrate shall commit the said Leper to a leper asylum to be detained as aforesaid.

7. It shall be lawful for the Governor if he shall think fit to direct any Leper who may be detained in any prison or in any lunatic asylum to be removed to a leper asylum and there to be detained — In the case of a prisoner until his sentence shall expire or he shall be cured and returned to prison whichever shall first occur and in the case of a lunatic until he shall recover from his lunacy or until he shall be discharged by order of the Governor.

8. The Colonial Secretary may by order in writing direct the removal of any Leper from any leper asylum to any other leper asylum and such order shall be sufficient authority for the removal of such Leper and also for his reception into such other asylum.

9. The Governor may by order in writing at his absolute discretion direct the discharge from any leper asylum of any person detained therein as a Leper under the provisions of this Ordinance and shall so direct the discharge of any person so detained upon the certificate in writing of the medical officer of the asylum that such person is cured of his leprosy.

10. Every person who shall purchase or receive from any inmate of a leper asylum any food clothing or other article shall be liable on summary conviction to a fine not exceeding ten pounds or to imprisonment with or without hard labour not exceeding two months or both.

11. No Leper who is not a native of Fiji shall land at any of the ports of the Colony from any place outside the Colony. And the master or other person in charge of any vessel who suffers or permits or omits to prevent the landing from such vessel at any such port of any person whom he knows or has reasonable grounds to suppose to be a Leper shall be liable on summary conviction to a fine not exceeding one hundred pounds.

12. Every Leper so landing as aforesaid may be committed to a leper asylum by a warrant under the hand of the Governor and may be detained therein for such period as may be directed by such warrant.

13. Every Leper so landing as aforesaid may be brought before a Stipendiary Magistrate who may examine such Leper and any other witness on oath touching the place from which he was brought into the Colony and may cause such Leper to be removed to the place from which he was so brought in such manner as the Governor may direct and the reasonable cost of such inquiry and removal shall be borne and paid by the master or other person in charge of the vessel by which such Leper was brought to the Colony by whose act or default such Leper was permitted to land and such cost may be sued for and recovered in a summary manner before any Stipendiary Magistrate as a debt due to the Crown.

14. Every person received into a leper asylum under any warrant issued under the provisions of this Ordinance may be detained therein until he be removed or discharged and in case of escape may by virtue of such warrant be captured by the

officer in charge of such leper asylum or any officer or servant belonging thereto or any Police officer and be again conveyed to and received and detained in such leper asylum.

15. No supposed Leper shall be convicted of an offence under this Ordinance or shall be committed to a leper asylum or removed from the Colony under the provisions of this Ordinance and no person shall be convicted of any offence with respect to the landing of any supposed Leper except on the evidence of a duly qualified medical practitioner that such supposed Leper is a Leper.

16. (1) Subject to the provisions of this Ordinance the Governor in Council may make rules in respect of all or any of the following matters:—

a) The forms of the certificates warrants and orders to be used under this Ordinance;

b) The management inspection and control of leper asylums:

c) The visiting of Lepers in leper asylums by their relations and friends;

d) The appointments and duties of officers in charge of leper asylums;

e) Any other matters as to which it may be expedient to make rules of carrying into effect the objects of this Ordinance.

Provided always that such rules shall make provision—

f) For the making of monthly reports to the Governor by the officer in charge of every leper asylum with regard to the number of Lepers detained therein and their condition and the requirements and conditions of such leper asylum;

g) For the visiting at least once in every six months of every leper asylum by the Governor or by some officer deputed by him.

(2) Such rules shall be published in the ***Royal Gazette*** and shall as soon as practicable be laid upon the table of the Legislative Council and unless and until disapproved by the Legislative Council shall have the same force as if enacted in this Ordinance.

17. Unless and until a rule be made under subsection (g) of section sixteen every leper asylum shall be visited by the Colonial Secretary or by some other officer appointed by the Governor once at least in every six months.

18. No action suit or other proceeding shall be brought against any qualfied medical practitioner for any certificate given or for thing done in good faith in pursuance of the provisions of this Ordinance or of any rule made thereunder.

19. Any person committing any breach of this Ordinance or any infringement of any of the provisions thereof or of any rules made thereunder for which no penalty is expressly provided by this Ordinance shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding five pounds or to imprisonment with or without hard labour for any term not exceeding one month.

20. This Ordinance shall not come into operation unless and until the Governor notifies by Proclamation that it is Her Majesty's pleasure not to disallow the same and thereafter it rhall come into operation within such area or areas and upon such day or days as the Governor shall notify by the same or any other proclamation.

Passed in Council this eleventh day of July in the year of our Lord one thousand eight hundred and ninety-nine.

SCHEDULE.

List of Trades or Callings the carrying on of which by Lepers may be prohibited by the Governor in Council under section three—

Baker
Butcher
Cook
Or any trade or calling in which the person employed comes in contact with articles of food or drink drugs medicines or tobacco in any form
Washerman
Tailor
Or any trade or calling in which the person so employed manufactures handles or comes in contact with wearing apparel
Barber
Or any trade or calling in which the person employed comes in contact with other persons
Domestic servant
Nurse
Midwife
Hawker
Hackney-carriage driver.

Fiji. Legislative Council. 1901.

COUNCIL PAPER, No. 31.

Rules made under the provisions of „The Lepers Ordinance 1899".

Approved by the Legislative Council, 1901.

The following Rules are made by the Governor in Council under the provisions of „The Lepers Ordinance 1899".

Forms.

1. The forms of Warrants, and Order, and Medical Certificate, to be used in giving effect to the Lepers Ordinance 1899, shall be those in the Schedule attached to these Rules, viz., Forms A, B, C, or D, as the case may require.

Superintendent.

2. The person appointed by the Governor, under section 5 of the Lepers Ordinance, No. VII of 1899, to be the officer in charge of the Asylum may, for the purposes of these Rules, be called or styled the Superintendent.

Officers.

3. The Superintendent shall be assisted by a duly qualified Native Practitioner, and by a Chief Warder, and by such further staff of attendants as, with the sanction of the Governor, he may from time to time appoint.

Chief Medical Officer to supervise.

4. The Chief Medical Officer of the Colony shall exercise a general supervision and control over the management of the Leper Asylum, and over the expenses of its administration, in accord with the supplies voted by the Legislative Council for its maintenance.

Official Visitor.

5. The Governor or some officer deputed by him for the purpose shall visit and inspect the Leper Asylum at least once in every six months. In the case of such inspection being made by deputy the inspecting officer shall submit his report thereof to the Governor.

Report by Superintendent.

6. The Superintendent shall also submit a report, throug the Chief Medical Officer, for the information of the Governor, once in every calendar month, showing the number of lepers detained in the Asylum, and their condition and requirements, and the condition and requirements of the Asylum.

Register to be kept.

7. The Superintendent shall keep a Register, in a form to be prescribed by the Chief Medical Officer, of all the lepers received into the Asylum, in which there shall be recorded the names, age, sex, and nationality of every case, together with the date of admission, the kind of warrant or order under which the case was committed, the address of the place to which he belonged, the name of his principal surviving relative at the time of admission, and the date of discharge or death as the case may be. In the cases of discharged patients the reason for such discharge shall also be entered in the register. The entry of these particulars shall be made at the visit of the Superintendent next ensuing, as the case may be.

Case Book.

8. The Superintendent shall keep a Case Book in which he shall enter a clinical description of each leper's condition when admitted and from time to time thereafter as may seem expedient, and, also, a Treatment Book for the guidance of the Chief Warder who shall see the directions contained in it are duly carried into effect.

Visits and Communications.

9. No person unconnected with the Asylum shall have access to any part of the Asylum or its grounds except with the written permission of the Superintendent, which must be duly exhibited to the Chief Warder.

Terms on which Visits allowed.

10. Persons desiring to visit their relative or friend detained in the Leper Asylum, or showing other sufficient reason for desiring to communicate with any patient, may apply to the Superintendent, who, if he see fit, may give permission in writing addressed to the Chief Warder for them to do so; but all such interviews shall take place (unless the leper be ill and confined to the infirmary) outside of the inner zone of the Asylum premises and in the presence of the Chief Warder or of a salaried attendant deputed by him to be there. The Superintendent may refuse permission to any applicant to visit a patient if he have good reason to believe such visit inexpedient.

Food, &c., may be brought by friends.

11. Visitors may bring gifts of food or clothing or domestic comforts for patients; but all such articles shall be handed to the Chief Warder who shall use his discretion as to whether they shall be presented or not.

No Food or Clothing to be carried away.

12. No visitor to the Leper Asylum shall convey away any article of food or clothing therefrom, nor any gift whatsoever unless it have been first disinfected to the satisfaction the Superintendent.

[illegible] beyond the Asylum must [illegible] the Chief Warder must [illegible] Superintendent before transmitting [illegible] at the first opportunity

[illegible] under the direction and [illegible] and any disobedience [illegible] these Rules.

[illegible] including breach [illegible] either by fine in money [illegible] offence, or by confine[illegible] seven days. Every such [illegible] be kept by the Super[illegible] by the officer

[illegible] punishable by the [illegible]

6. Inspect utensils, and record deficiencies and defaulters.
7. Issue medicines and dressings as prescribed by the Superintendent or the Native Medical Practitioner, and see that they are duly applied.
8. Inspect the water-supply, and set right any defect discovered, as far as practicable.
9. Inspect the latrine accommodation and take measures for securing the proper removal of excreta.
10. Hear complaints, inquire into quarrels, and adjust matters of contention as far as is in his power, reserving such points as may be necessary for the consideration of the Superintendent.
11. Give the necessary directions for the conduct of „communal" or public work in food planting, &c., and see that this is properly attended to.

The Chief Warder will also hold an Inspection weekly of clothing and bedding issued to the inmates. The Chief Warder will unterdake the disinfection of articles ordered by the Superintendent to be disinfected or requiring in virtue of these Rules to be disinfected, and he will foward disinfected letters for post.

Treatment of Prisoners and Lunatics.

18. Inmates of the Leper Asylum transferred to it from a Lunatic asylum or a Prison shall be treated in accordance with the principles applicable to lunatics and prisoners of the Crown respectively, in so far as is practicable.

SCHEDULE.

„THE LEPERS ORDINANCE 1899."
(Section 4 and Section 6).

FORM A.

Magistrate's Warrant of Commitment to a Leper Asylum.

To of and to all Constables and other Peace Officers within the Colony of Fiji and to the Officer in Charge of the Leper Asylum at

Whereas of was on the day of 19 examined by and before me at under and by virtue of the powers conferred upon me by the Lepers Ordinance 1899 and was convicted of

And whereas having called to my assistance a qualified medical practitioner and being satisfied by evidence that the said is a Leper within the meaning of the aforesaid Ordinance.

Now therefore I commit the said to the Leper Asylum at to be detained there until discharged by order of the Governor.

Given under my hand,

Dated this day of 19 ,
at

Stipendiary Magistrate.

„THE LEPERS ORDINANCE 1899.“

FORM B.

Medical Certificate.

I the undersigned being* hereby certify that I on the day of 19 at in the Colony of Fiji personally examined a** describet to me as† and that the said† is in my opinion a Leper within the meaning of the Lepers Ordinance 1899.

I have formed this opinion on the following grounds, yiz.:—

(Signed)

Place of abode

Dated this day of 19 .

*Here set forth the registered qnalification to practise. ** Insert „male adult“ or as the case may be. † Here quote name.*

„THE LEPERS ORDINANCE 1899.“

(Section 7).

FORM C.

Governor's Order for the Removal and Detention of a [Prisoner *or* Lunatic] *to a Leper Asylum.*

To the Superintendent of [*Prisons* or *the Public Lunatic Asylum*] and to the Officer in Charge of the Leper Asylum at

I Governor of the Colony of Fiji having receive the Medical Certificate hereunto attached in reference to the bodily condition of at present detained in the* at do hereby order and direct you the said Superintendent to cause the said to be removed under proper custody to the Leper Asylum at and I do order and direct you the said Officer in Charge of the said Leper Asylum to receive and detain the said as a patient therein until discharged in accordance with law.

Dated at Suva this day of 19

(Signed)

Governor.

* *Here insert the words* „Prison“ *or* „Lunatic Asylum“ *as the case my be.*

„THE LEPERS ORDINANCE 1899.“

(Section 12).

FORM D.

Governor's Warrant of Commitment to a Leper Asylum.

To of and to all Constables and other Peace Officers within the Colony of Fiji and to the Officer in Charge of the Leper Asylum at

Whereas lately of in the of not being a native of Fiji, and having landed in the Colony in contravention of the provisions of the Lepers Ordinance 1899, and

Whereas it has been shown on the evidence of a duly qualified medical practitioner that lately of in the of is a Leper, and whereas the said did on the day of 19 land at the port of from a place outside the Colony, the said not being a native of the Colony.

Now therefore I commit the said to the Leper Asylum at to be detained therein until cured or otherwise discharged according to law.

Given under my hand,

Dated this day of 19 ,
at

Governor.

Approved by the Legislative Council, this twenty-eighth day of September, 1901.

A. Langton,
Clerk to the Council.

British India.

Bericht

von

Wellesley C. Bailey in Edinburgh.

Outline of the Paper.

A. Increase or Decrease of the Disease since tho First International Conference in 1897.

B. Methods employed to battle with the disease during the same period.
   1. Laws of Government.
   2. Cooperation of Government with Philantropic and Missionary Institutions.
   3. Recent Incidents.

C. General Information on:
   1. How Lepers travel.
   2. Treament of lepers in ordinary Hospitals.
   3. Employment for Lepers in Asylums.

Explanatory Note: This Paper does not touch upon any Medical Question except indirectly, the writer not being qualified to treat of that Branch of the Subject. Such questions must be left in the hands of Members of the Medical Profession.

A. Increase or decrease of the disease since the first international leprosy conference in 1897.

It is impossible to give Official Statistics for the period asked for, viz: 1897 to 1903, as they are not published annually. The Writer has therefore thought it better to take those for the last published decade that is for 1891—1901, and as the period embraces five of the seven years asked for the figures will be found fairly satisfactory, and thev will at least give an indication as to whether Leprosy is on the increase or decrease.

The study and comparison of the figures given in the Census Reports of 1891 and 1901 lead to the irresistible conclusion that the disease is on the decrease, and indeed, if the figures are to be trusted, to the very gratifying conclusion that the decrease is very rapid.

There is no doubt however that two severe famines and a con-

tinuance of the Plague in many parts of India account for the extraordinary decrease in some of the Provinces.

Speaking of the decrease among males in Berar, the Census says: —

„The decrease among males is very considerable since 1891, viz:—961 and is probably due to a great extent to the high mortality among them at the last two famines".

In the Bombay Presidency, where the number of afflicted per 10000 of the population shews for the last three Decades the following remarkable figures, viz:— for 1881 (12): 1891 (10): and for 1901 (6), the Census says: —

„The recent misfortunes of the Province through famine and plague have largely reduced the leper population." (Apparently by about 40%).

Notwithstanding these very probable aids to decrease, there must still be a very remarkable shrinkage in the leper population of India, for even when one makes every allowance for possible errors those errors, if they exist, are remarkably uniform.

Take for instance the case of the Panjab and North West Frontier where the figures for the last three Decades are as follows: —

1881	1891	1901
9734	6271	5036

The Census says:—

„The figures may be taken as substantially accurate. The number of lepers in 1891 decreased by 36% on the Returns of 1881 which again had shewn a marked decrease on the figures of 1868. The present figure shews a further decrease of nearly 20% and the number of persons now returned is only 18 in every 100000 as against 43 in 1881."

In the Bengal Presidency which has the largest leper population there are according to the Census for 1901:— Males 27 081: Females 8428: Total 35 509.

The Report says: —

„The present Census shews a decrease in the prevalence of the disease, and the number of lepers now recorded is less by 19% than it was in 1891. The improvement is shared by all parts of the Province except the Chota Nagpur Plateau where Manbhum and the Sonthal Parganas shew a much wider diffusion of leprosy than in 1891. As these Districts border on Bankura and Birbhum where it is more prevalent than in any other part of Bengal or, for that matter, of India, it is not unlikely that there has been a genuine spread of the disease. Outside Chota Nagpur the least improvement is shewn in Orissa. Elsewhere the decrease is very marked. In South Bihar and Saran it is reported that the lepers suffered more from plague than any other class of the community, and Mr. Oldham, Magistrate of Gaya, states that since the plague epidemic he has noticed a marked diminution in their number in Gaya Town. Their mode of living and the sores engendered by their disease would naturally render them specially liable to infection. The decrease, however, is equally noticeable in Central and Eastern Bengal where there has been no widespread outbreak of plague". „There is also a fairly widespread opinion that the

disease is really becoming less common. The decline of leprosy in Europe is attributed mainly to improved hygienic habits and surroundings, and to increased material prosperity, and it may be hoped that the same causes will gradually bring about its disappearance from India".

The number of lepers per 100000 of the population for the different divisions of Bengal is as follows:—

Western Bengal	116
Central „	31
Northern „	42
Eastern „	22
North Bihar	28
South „	44
Orissa	109
Chota Nagpur Plateau	58

An interesting note to the Bengal Census Report is as follows:—

„Neither does the hypothesis that it is due to the use of badly cured fish find any corroboration in the excessive prevalence of the disease in Birbhum, Bankura and Manbhum. Very little fish is imported to these districts and it enters but very slightly into the diet of the people."

The Returns for Berar are rather remarkable, for while male lepers there have decreased by 1046 since 1881 the number of females has risen by 85.

The figures given for Burma are very interesting. Here too a very large decrease is shewn.

One Table shews a comparison between Burma and India as a whole as follows:—

Average per 100000 of each sex afflicted compared with India as a whole:—

1891.	Males.	Females.
Lower Burma	92	31
Upper „	160	81
Burma	117	52
India as a whole	68	23

1901.	Males.	Females.
Lower Burma	49	17
Upper „	82	17
Burma	61	27
India as a whole (1891)	68	23

Two things will be observed from this Table, viz:—

Burma all over has a larger proportion of lepers than India as a whole, and that the same remarkable decrease has taken place in Burma as elsewhere.

The total figures for Burma are as follows:—

	1891	1901
Males	4543	2904
Females	1921	1250
	6464	4154

A decrease of nearly one-third.

The writer of the Burma Report in speaking of this remarkable decrease says: —

„The difference is, I believe, mainly due to more careful enumeration, but I should hesitate to say that we should not be justified in according the excellent Institutions referred to (viz:— two Asylums in Mandalay and one in Rangoon) some small portion of the credit for the improvement in the figures. By next Census it is to be hoped that they will have made their influence indisputably felt."

For the Province as a whole the ratio is 56 males and 25 females in every 100000 of the sex concerned.

In the Central Provinces the figures are as follows: —

	1891.	1901.	Decrease.
Males . . .	4374	3320	1054
Females . .	2240	1778	462
	6614	5098	1516

The Report says:—

„The rate of reduction can hardly be so great as would appear from the figures or they would vanish altogether within a measurable term of years".

Madras figures read: —

Total lepers in 1901:— Males 10207: Females 3356: Total of both sexes 13563.

Proportion of lepers to a million during last three Decades: —

1881 . . .	Lepers	466
1891 . . .	„	353
1901 . . .	„	351

There is a remarkable note to this effect: —

„Of the number of the three main religions, Christians are more affected with leprosy than the others, the frequency of the disease among the Eurasians, which is greater than in any other caste or race in the Presidency, bringing up the percentage."

In Baroda we find also a steady decrease, the relative figures being: —

	1891	1901
Total number afflicted . . .	569	277

or per 10000 of the population: —

	1891	1901
Males	3.17	1.8
Females	1.48	1.0

An interesting note under the Baroda Report is the following: —

„The fishermen and Bhois are quite free (from leprosy). This is

against the notions of some who consider the fishermen susceptible to this disease."

· (The Bhois are palanquin bearers and fishermen.)

In Hyderabad there must surely be some mistake in the figures which read as follows:—

	Males.	Females.	Total.
1881 . . .	2117	872	2989
1891 . . .	2261	716	2977
1901 . . .	236	94	330

The lepers could scarcely have decreased in a Decade from 2977 to 330.

The Report says:—

„As regards the figures of 1881 and 1891, no great reliance could be placed on them for the reason that the Agency then available was too ignorant to understand the instructions issued for their guidance".

Mysore.

There is an interesting note in the Report to the effect that the number of Christians afflicted is very high: in the case of Christian females the number being far larger than that of any other religion.

The figures given for four Decades seem to point to some serious errors in past enumeration — still, they point to the fact that the disease is on the decrease. They read:—

1871	1881	1891	1901
1497	533	802	657

Rajputana.

„The number of persons returned as lepers is 461 or one in every 21092 of the population, as against 1708 or one in every 7020 of the enumerated population in 1891". (An apparent decrease of nearly three fourths.)

The Report goes on to say:—

„The disease has decreased in every State and there seems ground for hoping that *it is gradually dying out*." (The italics are mine.)

The total leper population of British India, according to Official Statistics, is 97340 for 1901 as compared with 126244 for 1891, or a decrease of 28904 in the Decade. By sexes the two Decades read as follows:—

	1891.	1901.
Males . . .	95 218	72 403
Females . .	31 026	24 937
Totals	126 244	97 340

That is one leper to every 2951 of the population in 1901 and one to every 2275 in 1891.

I now proceed to set out in detail according to Provinces and Native States, as far as figures are available the results of the Census for 1901:—

Provinces.

	Males.	Females.	Persons.
Ajmer-Merwara	19	6	25
Andamans	34	—	34
Assam	3 938	1 150	5 088
Baluchistan	—	1	1
Bengal	27 081	8 428	35 509
Berar	1 925	862	2 787
Bombay & Sind (with Aden) .	4 117	1 602	5 719
Burma	2 940	1 250	4 190
Central Provinces	2 808	1 494	4 302
Coorg	6	3	9
Madras	10 122	3 332	13 454
N. W. Frontier & Panjab . .	2 506	926	3 432
United Provinces	8 839	2 489	11 328
	64 335	21 543	85 878

States.

	Males.	Females.	Persons.
Baroda	182	95	277
Bengal States	1 305	563	1 868
Bombay States	878	308	1 186
Cen. India Agency	272	154	426
Cen. Provinces' States . . .	512	284	796
Hyderabad	236	94	330
Kashmir	1 107	490	1 597
Madras	1 334	538	1 872
Mysore	463	209	672
Panjab States	1 186	418	1 604
Rajputana Agency	302	159	461
U. P. States	291	82	373
Baluchistan Agency	—	—	—
	8 068	3 394	11 462
Total-India	72 403	24 937	97 340

The following Table based on the figures of the Census Report of 1901 shews the incidence of the disease per 10 000 of each sex and of the total population.

Provinces.

	Males.	Females.	Total Pop.
Ajmer-Merwara	.756	.265	.510
Andamans & c.	18.186	—	9.093
Assam	12.208	3.855	8.031
Baluchistan	—	.077	.038
Bengal	7.245	2.255	4.750
Berar	13.870	6.338	10.104
Bombay	4.295	1.784	3.039
Burma	5.503	2.427	3.965

	Males.	Females.	Total pop.
Central Provinces	5.782	2.975	4.378
Coorg	.598	.373	.485
Madras	5.372	1.720	3.546
Panjab & N. W. F. Province	2.070	.894	1.482
United Provinces	3.591	1.078	2.334

Native States.

	Males	Females	Total Pop.
Baluchistan Agency	—	—	—
Baroda	1.804	1.006	1.405
Bengal States	6.863	3.047	4.955
Bombay States	2.499	.909	1.704
Central India Agency	.614	.366	.490
Central Provinces' States	5.177	2.818	3.997
Hyderabad	.415	.171	.293
Kashmir	7.178	3.600	5.389
Madras States	6.365	2.574	4.469
Mysore	1.655	.762	1.208
Panjab States	4.921	2.074	3.497
Rajputana Agency	.591	.344	.467
United Provinces States	7.021	2.115	4.568

Totals.

	Males	Females	Total Pop.
British Provinces	6.113	1.849	3.981
Native States	3.469	1.522	2.495
All India	4.791	1.685	3.238

While I think we may trust these Statistics as to the undoubted decrease of leprosy during the last thirty years, and especially so during the last ten years, I do not think the same can be said of the statistics as a whole.

In the one case the decrease is steady every Decade, under the same plan of enumeration with the same class of enumerators and the same instructions to the enumerators for at least two Decades, in the other the same instructions, the conditions of native life, the feelings of the people with regard especially to their female relatives and the ignorance of the enumerators as to what is true leprosy and what is not would all tend to keep down the figures vastly below what is really the case. In other words, I am convinced that 97 340 as the total leper population of British India is simply not to be thought of.

The instructions given in all cases were to the effect that only those suffering from a corrosive form of the disease were to be tabulated, and that all suffering from white leprosy or leucoderma only were to be excluded. Now anyone who has seen a number of lepers together in an Asylum can readily understand what a large percentage of them would escape through the meshes of the „corrosive“ net — a great many advanced cases of tubercular leprosy would thus escape to say nothing of the numerous cases of incipient leprosy. I have had it

said to me that not all the inmates in certain Asylums were lepers, whereas I knew for a fact that they were.

As regards leucoderma — It is well known that many lepers have white patches on different parts of their bodies. Seeing such white patches, the unskilled enumerator would at once jump to the conclusion that it was a case of simple leucoderma. If this can be maintained in the case of an Asylum where all are lepers, how much greater will be the risk of lepers being passed over in the ordinary crowd.

We have also to bear in mind that as a general rule the enumerators do not see those about whom they are striving to get correct information but have to take on trust what the Village Headman or some male relative tells him, and that in the case of an infirmity such as blindness, deafmutism, insanity or leprosy, especially in the case of the last named, which is a loathsome disease and carries with it a stigma, it is the object of the relatives, at all events it is to their advantage to keep these things hidden.

Anyone who has seen the Census enumerator in India and his clerk taking the Returns in a smallnative village will readily understand the likelihood of what I say.

Then, we have to remember, the great reticence of the ordinary Indian with regard to his female relatives, and that as a great number of women are entirely excluded from the public gaze, it is quite impossible to get trustworthy information regarding them, while a great number of the women of even the middle and low castes would flee into seclusion on the approach of the Census enumerator, so that unless the man wished to blaze abroad the fact that some of his female relatives were lepers he would not mention it. Is it likely then that even a fair proportion of the women suffering from leprosy ever get into the Returns at all?

A great deal of what has been said about female lepers might also be said about children suffering from the disease, and indeed for certain reasons the inducement to concealment in the case of children is even greater than in the case of the women. What parent, either Indian or European, would like to let it be known that his child was suffering from this loathsome disease? And yet, alas, those who have had experience of lepers in India know well that a great number of children do suffer from the disease.

Take one leper Asylum in India — that of Purulia, in Bengal — and what do we find? viz: — Out of a total of 577 lepers 48 are children under fourteen years of age.

Let me, however, cull from the various Reports in the Census of 1901 a few statements in support of my contention. The general instructions to all enumerators I have given above.

Assam Report.

„No one except the professional beggar is anxious to publish his infirmities.“

Berar.

„Leprosy can be correctly diagnosed only by scientific experts.“

„The people are generally reticent in mentioning such infirmities specially with regard to the female members of their family."

Burma.

„The danger of overlooking the infirmity column is ever present both in the cases of enumeration and abstraction."

Again, „Placed as that column is at the edge of the schedule and almost hidden on the left hand page, when the book is doubled it was inevitable that here and there an entry should evade even the most vigilant eye".

Central Provinces.

„The enumerator's diagnosis is capricious."

Coorg.

„The figures (re infirmities) are probably rendered inaccurate by the difficulty the enumerators experienced in correctly diagnosing these diseases and by the reluctance felt by parents in admitting that their young children were afflicted by them."

Madras.

„It is almost impossible for persons of the slender attainments of the average Indian enumerator to diagnose doubtful cases with certainty and to decide for example whether an individual is suffering from lupus or from leprosy."

Panjab.

Speaking of insanity and leprosy:— „No attempt could possibly be made in a Census to ascertain the degree of insanity or leprosy and the figures for these infirmities are probably less accurate than those for" (the other infirmities).

Central India.

Speaking of a former Census for this great division of India, Sir Lepel Griffen said:— „The Census Returns of Central India are, for comparative and deductive purposes, not worth the paper on which they are written."

The present Report says:— „Leprosy is the only affliction which is likely to be kept back."

„The real source of error is failure of diagnosis."

„It (Leprosy) is the one affliction of the four with which we deal however that they (the people) are likely to conceal."

Cochin.

„They (the enumerators) generally feel some delicacy in making enquiries about infirmities, and the informants, in their turn, are equally reluctant when questioned to furnish the required information."

Hyderabad.

Speaking of the difficulties of enumeration in the case of infirmities:— „The difficulty assumes formidable proportions in such tracts

of country as this State where the Zenana system prevails and the enumerators have to depend solely for their information regarding females and children on the male members of the family."

Rajputana.

„An enquiry into the infirmities of the members of a household is always a delicate and difficult matter, and it is doubly difficult in a Country where the people are very sensitive on the subject of their women-folk and intensely dislike admitting that they have any personal blemishes or are suffering from disease, especially from so loathsome a disease as leprosy. That there have been omissions, more especially among the females, is certain."

„The Return is no doubt incomplete since leprosy carries with it certain social disabilities, and there is naturally great reluctance to admit the existence of this dreadful disease. Incipient cases too are bound to be overlooked, for the leper himself is often ignorant of the fact that he has the taint."

It would be hazardous in the extreme to commence guessing at the real figures for the leper population of India, and there is nothing much to be gained by so doing, yet we cannot but feel that they are immensely in excess of the numbers given in the Official Returns. How far in excess it would be impossible to say, but we are convincend that it is so.

B. Methods employed to battle with the disease during the same period.

1. Laws of Government.

In the year 1898 a new Leper Act was passed by the Supreme Government of India entitled „Act No. III of 1898".

That Act received the assent of the Governor General on the 4th February of that year. (It will be found in the Appendix.)

To this has since been added an Amendment Act — „No. XIII of 1903", making the foregoing Act of 1898 applicable to Native States in British India.

Now, while it is true that this Act stands upon the Statute Book, it has been but little enforced as yet.

It will be observed that while it has been enacted for all India, it is left to the discretion of the different Provincial Governments whether they will enforce it or not.

The Act has, in a more or less modified form, been put into force in Bengal, in the United Provinces, in Bombay, in Burma and in the Central Provinces, but in no Province, so far as I can gather, have its provisions been strictly carried into effect, and one cannot but feel that it is as yet regarded but as a tentative measure. It is however an honest attempt on the part of Government to grapple with the Leper Problem.

2. Co-operation of Government with Philanthropic and Missionary Institutions.

Among the efforts made to fight leprosy in India since 1897 the cooperation of Government with Philanthropic and Missionary Institutions must be regarded as both hopeful and encouraging.

In the Panjab where there is a large Leper Settlement at Tarn Taran, which was a source of some anxiety owing to its insanitary condition and also to the promiscuous way in which diseased and healthy men, women and children were allowed to live there, the Government have made over the whole place to the charge of the „Mission to Lepers in India and the East", giving at the same time a grant of 30 000 rupees towards the rebuilding of the settlement — the Mission, on its part, supplying other 15 000 rupees.

In Bengal, the Provincial Government has declared the Leper Asylum of the Leper Mission at Purulia to be an Asylum under the Act, and has established a Government side to the Institution. This was formally opened on the 2nd December 1903.

As well as this, the Bengal Government is giving an Annual Grant of money towards the up-keep of the Institution and is helping in other ways.

At Mandalay, Upper Burma, at Sholapur and Nasik in the Bombay Presidency, and at Mungeli, Dhamtari, Chandkuri and Wardha in the Central Provinces, the Provincial Governments are giving grants of various amounts towards the work of the Leper Mission in these places.

At Mandalay also, the Government is aiding the Roman Catholic Leper Home to a large extent.

While we cannot say that the various Governments are yet supporting the work of the Missionary and Philantropic Institutions as we consider that they ought, yet they have, within the last seven years begun to recognise their responsibilities in the matter, and we believe that they begin to see that the best solution of the Leper Problem lies not so much along the lines of hard and fast legislation as in a happy co-operation with recognised Philanthropic Agencies, where the voluntary principle is in force, for it is found that the helpless diseased leper, the very one who is really a source of danger, is very willing to avail himself of the shelter and help of such Institutions and thus become segregated from the healthy portion of the Community.

It is this very voluntary principle which Government is now, we hope, beginning to recognise as the true solution of the Leper Problem, and along these lines lies the road to success:— viz:—

Gentle force on the part of the Government, just far enough to strengthen the hands of those in charge of the various Philanthropic Institutions, and liberal grants of money to enable such Agencies to erect sufficient accomodation for the housing of the unfortunate victims of this foul disease, and also to support them when so housed.

When the late Archdeacon Wright wrote his Book — „Leprosy and its story — Segregation its remedy", he was right as to the remedy implied in the second part of his title.

Segregation in the first place of the unfortunate victims of this disease from the community in general, and in the second place segregation of the as yet untainted children of leprous parents from their parents and indeed from all leprous relatives.

While we cannot agree with all of the report of the Leprosy Commission of 1890 and 1891, especially with their views on contagion, viz:— „That the extent to which leprosy is propagated by contagion is very small“ and hence „that no legislation is called for on the lines of segregation or of interdiction of marriages with lepers“, we do most heartily agree with their pronouncement that „Leprosy is not diffused by hereditary transmission“ which pronouncement was most emphatically endorsed by the „National Leprosy Conference of 1897“.

Hence we regard the segregation of the as yet healthy children of lepers from their diseased relatives as one of the most practical steps which has been taken in the fight against this disease in India during the last seven years.

So far as we are aware the „Mission to Lepers in India and the East“ is the only Body that has adopted this manoeuvre, shall we call it, in its warfare against this disease. The Mission to Lepers has added several new Homes for children during the last few years though this work was begun many years ago. In these Homes the results gained have been more than encouraging — they have been beyond the most sanguine expectations successful. Practically the whole of the children thus cared for during the past twenty years have escaped the disease, the very few exceptions being in all probability cases of contagion rather than heredity.

Many of the children thus rescued in their childhood have since married and have become parents, and neither in them nor in their offspring is there any sign of the disease.

To quote again from the pronouncements of the Leprosy Commissioners, we find the following: „No authentic congenital case has ever been put on Record nor was one seen in this Country“.

And speaking of one of the Homes for the rescue of such children which they had visited and where they had spent considerable time in making investigations they wrote as follows:

„The facts obtained from the Orphanage at the Almora Asylum disprove the existence of a specific hereditary predisposition.“

The Government of India would be well advised if they were to encourage the establishment of such Homes as we have mentioned by every means in their power, for we regard these Homes as strategic outposts in this warfare.

In a comparatively recent article by Dr. Ernest F. Neve of Kashmir, which appeared in the British Medical Journal, we find the following striking sentences:

„Heredity appears to play but a small part“.

„Children of lepers at birth are free of the disease, but unless separated from their parents they are almost sure to develop it within a few years“.

„If the disease is to be stamped out, the most important measures to be taken are, in my opinion, first to separate healthy children from

their leprous parents; secondly to withdraw lepers from the general community as completely as possible."

During the past seven years the „Mission to Lepers" has established sixteen new centres of work where they have either built or are about to build new Asylums.

The operations of this Mission in India at the present time are as follows:

Station.	M.	W.	L. Ch.	Un. Ch.	Total
Alleppey	23	7	2	—	32
Allahabad	36	13	4	—	53
Almora	40	41	1	11	93
Ambala	13	6	—	2	21
Asansol	49	32	4	18	103
Attingal	—	—	—	42	42
Bankura	43	10	—	13	66
Bhagalpur	72	32	5	5	114
Calicut	28	11	—	8	47
Chamba	9	11	—	—	20
Champa	17	14	2	3	36
Chandag	43	38	—	—	81
Chandkuri	218	191	20	92	521
Dehra	85	36	—	1	122
Dhamtari	43	55	1	26	125
Ellichpur	18	3	—	1	22
Govindpur	10	3	—	—	13
Harda	18	15	3	3	39
Lohardaga	29	1	—	11	41
Ludhiana	8	4	—	1	13
Mandalay	103	40	28	11	182
Mangalore	5	3	—	—	8
Maulmain	20	4	1	—	25
Meerut	15	4	—	—	19
Miraj	32	10	1	—	43
Moradebad	16	6	—	—	22
Mungeli	41	34	2	9	86
Muzaffarnagar	16	8	2	2	28
Muzaffarpur	9	1	1	2	13
Nasik	39	34	3	8	84
Neyoor	24	11	2	4	41
Patpara	13	10	—	9	32
Pithora	—	—	—	2	2
Poladpur	64	40	—	—	104
Pui	34	25	1	7	67
Purulia	288	241	48	55	632
Ramachandrapuram	56	16	3	7	82
Raniganj	83	40	7	4	134
Rawal Pindi	35	15	—	20	70
Rurki	23	17	8	5	53
Carried forward	1718	1082	149	382	3331

Station.	M.	W.	L. Ch.	Un. Ch.	Total
Brought forward	1718	1082	149	382	3331
Sabathu	60	34	—	7	101
Saharanpur	16	5	—	—	21
Salur	9	1	—	—	10
Sholapur	32	24	22	18	96
Tarn Taran	87	57	2	19	165
Udaipur	4	—	—	—	4
Ujjain	21	16	5	—	42
Wardha	12	7	1	2	22
	1959	1226	179	428	3792

Forty-eight centres of work in all of which there is a Home of some sort.

Of these forty-eight Homes, the Mission owns thirty-eight for the upkeep of which it is responsible, the remaining ten are largely aided by the Mission.

In addition to the above Homes the Mission has a connection with and gives aid in some form to several others.

It will be observed that the total annual average of inmates is approximately as follows:—

Men	Women	Leper Children	Untained children
2000	1200	200	430,

or a total of 3830, and that the average number of inmates to one Home is about 80.

The rule of the Mission is the absolute segregation of the sexes, though, in a few cases, for various reasons, this rule cannot be strictly enforced.

The total cost of these operations during 1903 was about £ 18 300.

I think it will be conceded that this Mission is at present doing more than any other single Agency in India in the fight against leprosy.

Besides the Homes of the Mission to Lepers, there are, as far as we can gather four Roman Catholic Homes — one in Mandalay: one in Rangoon: one in Trombay (Bombay Presidency): and one in Mangalore (South India). — The Home in Mandalay, called the „St. John's Leper Asylum", being an exceptionally fine one with a splendid set of buildings and a fine staff of nurses — the present staff we believe consisting of two European Fathers and ten European Sisters. The number of beds available in this Institution are, for males 180 and for females 132. The daily average attendance is as follows:— Males 198: females 63 and children 27.

In their Report for 1902 and 03 we find that the Institution received about £ 300 from Government: £ 420 from Municipalities and £ 1000 from other sources.

As well as the Homes and Asylums which may be regarded as strictly Missionary, there are many others scattered over India, some under some sort of Government supervision, some which may be regarded as Municipal and a few as local charities.

It is very difficult to get a correct and up to date list of these but so far as I have information the principal are as follows, and may be considered as housing about 1600 inmates:

Madras Government Leper Hospital
Matunga Leper Home, Bombay
Trevandrum State Leper asylum
Calcutta Leper Asylum.

Other Asylums or Homes at Srinagar, Dharmsala, Baba Lakhan and Jalandhar in the Panjab: Agra, Bareilly and Lucknow in the United Provinces: Nagpur and Raipur in the Central Provinces: Poona, Ratnagari, Ahmedabad and Belgaum in the Bombay Presidency: Sehore in Central-India: Bangalore, Cochin and Trichinopoli in the Madras Presidency: Port Blair in the Andamans and Sylhet in Assam.

Surely operations such as these may be regarded as very important factors in the fight against leprosy.

3. Recent Incidents.

Amongst other incidents in the fight against leprosy during the last seven years may be mentioned the following:—

a) A Conference of Superintendents of Leper Asylums promoted by the Mission to Lepers. This Conference took place at Wardha in the Central Provinces in February 1902.

Amongst those who attended were several medical men, one of whom was a representative from the Government.

This Conference discussed many practical questions, such as:—

„Occupation for lepers living in Asylums".
„How to prevent lepers migrating from one Asylum to another".
„How to secure efficient workers, caretakers, teachers, compounders &c."
„The contagiousness or otherwise of leprosy".
„Medical treatment of lepers".
„Segregation of the sexes and of untainted children".

They came to some important conclusions among which those concerninge contagion were as follows:—

1. „The Conference as a body and as individuals is convinced of the contagious character of the disease of leprosy".
2. „The Conference regrets that the Leprosy Commission of 1890—1 whilst arriving at the same conclusion saw fit so to minimise it as to state that „under the ordinary human surroundings, the amount of contagion is so small that it may be disregarded".
3. „The Conference is of opinion that taking the figures given by the Leprosy Commission in their Report, and in viev of the extremely serious nature of the disease, lepers should be segregated".
4. „The Conference expresses its satisfaction that Government, notwithstanding the conclusions of the Leprosy Commission, have passed a Bill for the segregation of the Pauper Lepers, but it regrets that up to the present time Government have not seen their way to enforce it".

Major Buchanan, Indian Medical Service, the Government Representative at the Conference, gave an address on the contagiousness of Leprosy in which he dissented very strongly from the findings of the Leprosy Commission of 1890 and 91, and contended that the facts brought forward by the Commission did not justify the conclusion at which the Commission had arrived.

He wound up his address in the following terms:—

„A few years ago I was asked to choose a site, and draw out a plan for a leper Asylum at Nagpur. In the scheme that I drew up I laid stress on what seemed to me should be the leading principle in the management of such Asylums, — viz: that „attraction“ rather than „forcible detention“ should be the leading idea. I thought that the misery which these unfortunate people had already undergone and the terrible sentence which had already been pronounced on them by their fellowmen, who as a rufe look on them as outcasts, was already a very severe punishment, and that before we pass an additional sentence of „forcible detention“, it would be well to consider who is the offender?

Is it the unfortunate leper who has been allowed to come in contact with others from whom he has caught the disease or is it the successive Governments or Municipalities who have failed to take the necessary precautions to prevent the spread of a disease which has such terrible consequences? Believing as I do that leprosy is contagious and that it might have been checked years ago if steps had been taken to prevent contagion, I am convinced that this most unfortunate class have been more the victims of others neglect than offenders themselves, and therefore I think that in the management of Leper Asylums — while admitting that it is well to have the „forcible detention“ principle in reserve — still, this principle ought, as far as possible, to be kept in the background.

Having had an opportunity of visiting the Leper Asylum at Wardha and of hearing the views expressed by a number of men who manage Asylums which are largely supported by the Leper Mission, and having seen and heard that the leading idea in the management of such Asylums is „attraction“ and that the „forcible detention“ element is entirely absent, I think that these Asylums are deserving of the support of the Government. As I am the only Government Representative at this Conference, I shall consider it my duty to represent to the Central Provinces Government the good work which is being done in these Asylums and the desirability of contributing towards their support“.

b) The visit of the Organising Secretary of the Mission to Lepers to India where he made a tour of four months, during which time he visited many of the Asylums and Homes of the Mission and had some important interviews with Government Officials and others.

c) The appointment of a permanent Organising Secretary of the same Mission in India whose duty it is to visit and inspect the different Institutions of the Society in India and to confer with Government Officials and others as to the establishment of new Asylums &c.

C. General information on.

1. How Lepers travel.

With regard to the manner in which lepers get about from one part of the Country to another, and whether they are allowed to use ordinary public conveyances, I have taken great pains to get information and here give the results of my enquiries in the form of quotations from the various letters I have had upon the subject. I may say however that as a general rule the pauper leper travels on foot or crawls from one place to another, sometimes taking weeks to travel even short distances. The time comes however when he cannot even crawl and then he must either lie down and die or be carried in some way.

The Rev. T. G. Phillips of Mandalay writes.

„With reference to a leper's means of conveyance, I do not think any organised steps are taken to prevent the use by lepers of the ordinary public meaus of travelling: nor do I think that if the money is forthcoming would a leper be refused accommodation. I know, as a matter of fact, that conveyances ordinarily used by the Public are used occasionally by lepers.

The only restriction would arise from the general poverty of this class of persons. Few of them would have the means to pay for travelling.“

Dr. Stokes of Calicut, South India.

„With regard to your letter of 21st January 1904, how lepers travel about in India, I can give you the following information:—

It is really marvellous how far they can travel. Many a leper undertakes a pilgrimage to several holy places in India. It is chiefly at big festivals that you see most lepers. You could not conceive a better method of spreading the disease.

Travelling in the train one day, I saw a leper with bandaged feet amongst a number of pilgrims. I drew the attention of the guard to the fact that he allowed lepers to travel. „We are powerless“, he said, „as long as the medical men don't stop them“.

As far as my experience goes, I have seen lepers travel about in every public conveyance, unless the patient is too far gone. But Government in our Presidency has not passed any law as yet and so lepers can do what they like. I know of some lepers being clerks in offices and of others in trade.“

Dr. A. Nugent, Central India.

„There are absolutely no restrictions placed on lepers. I know of cases where lepers live with their family and carry on their business the same as other people. Some are fruit sellers, others vegetable dealers, meat or fowl dealers, shopkeepers, cloth sellers &c. If they are poor or so diseased that they cannot work they beg. When they are too far gone to be able to beg, or have no one to beg for them or help them, then they must die.“

Dr. A. Neve, Kashmir.

„I have no doubt that as far as Kashmir is concerned, lepers would be, and are allowed to travel by boats or ekkas. I do not personally know of their being refused accommodation.

I believe that many of them are too poor to travel except on foot. Any going from here to Tarn Taran have gone by ekka and rail.“

Rev. J. A. Cullen, Bhagalpur, Bengal.

„Lepers travel in all public conveyances in this Province without let or hindrance.“

Rev. G. M. Bulloch, Almora, U. P.

„I have not myself seen lepers travelling in public conveyances but I know that they have done so. Last year a leper came to us from Rurki on a visit and he told us he came by rail and would return by rail as far as Kathgodam.

I know of other cases. I have not heard of any being refused accommodation. I have seen lepers occupying rooms in the public rest houses in this District, and only a few months ago induced one in a rest house near the Town to come to the Asylum rather than eke out a miserable existence in the Dharmsala (Rest House). Others were occupying adjoining rooms. This is no unusual thing.“

From the Report of the Matunga Leper Asylum, Bombay:—

„Soon after the patients came in some of their friends and relations appeared to claim them and to undertake their maintenance and look after them. After due investigation locally, and at times lenthy correspondence with the different collectorates from which the patients had originally gravitated down to Bombay long long ago, some were discharged under the care of their guardians, and a few were actually seen to the Railway Station and sent off, their train fare and a small allowance for food on the way being paid from the Asylum Funds.

2. Treatment of Lepers in Ordinary Hospitals.

As to the treatment of lepers in ordinary hospitals and dispensaries lepers frequently appear as out-patients at the various civil and medical missionary Hospitals throughout India and are occasionally received as in-patients in some of the hospitals. For many years there was a leper ward attached to the „J. J.“ Hospital in Bombay.

3. Employment for Lepers in Asylums.

Regarding employment for lepers in Asylums — I fear a good many Superintendents of Asylums do not attempt much in the way of giving employment to the lepers under their charge. In many of the Voluntary Homes, however, some form of occupation for the inmates is looked upon as a necessity, and the devising of such occupation is an important part of the management. The inmates are encouraged to keep gardens, to help in the work of the Institution, such as carrying

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bricks for building purposes, to rear fowl, to learn to sew, to learn to read and so on.

In one leper Asylum under the Mission to lepers there is a Boys' Brigade composed of leprous lads. In others there are leper Musical Bands, and on special occasions games and competitions even are engaged in.

In the „St. John's Leper Asylum" in Mandalay the lepers have a boat of their own.

There is no doubt that it is good for the inmates to be employed and that it helps to do away with the terrible monotony of their lives and to keep the sufferers from brooding over their troubles.

At all the Institutions of the Mission to Lepers religious services are regularly held, but attendance on these services is quite optional.

In view of all the foregoing facts and especially the success which has attended the little that has as yet been done, one cannot but feel that if the Indian Government will take the matter up seriously and will do all in its power to encourage voluntary effort and work in cooperation with all such effort, that therein lies the road to success and the ultimate solution of the Leper Problem, and that given the above co-operation it is not too much to look forward to a not very distant future when leprosy in India may be held well in check and will gradually die out altogether.

Australien.

A review of leprosy in Australia during the 10 years 1894—1903 and a description of the measures in force there for control of leprosy.

By

J. Ashburton Thompson in Sidney.

With pleasure I respond to the invitation extended to me by direction of the President of this Conference to contribute to its proceedings a paper on the further incidence of leprosy on Australia. But I am obliged to ask leave to begin at a time somewhat prior to that of the Lepra-Conferenz, Berlin 1897, for the following reasons. That Conference marked a stage in the campaign against leprosy: and had an account of the progress of the disease in Australia down to 1897 been included in its Transactions it would have sufficed now to continue the subject from that date. But it happened that in that very year the Committee of the National Leprosy Fund of Great Britain had published „A contribution to the History of Leprosy in Australia[1]) which I had brought to a close in November 1894; whence it seemed unnecessary to furnish any further particulars at that time. Consequently, I contributed[2]) merely a condensed description of the more salient epidemiological points which, as it appeared to me, that detailed study had revealed. A summary Table was appended to it, indeed, which mentioned all the cases which had been recorded in New South Wales down to 1897, but for the rest of the Commonwealth only down to the year 1894. It seems best therefore to make the present account continuous with that contained in the above-mentioned work.

The notes which follow have been drawn entirely from official sources; the courteous cooperation of my colleagues in the several States has alone rendered the compilation possible. The Conference is thus indebted to Dr. J. C. S. Elkington, Chief Health Officer for the State of Tasmania; to Dr. Ernest Black, President of the Central Board of Health of the State of Western Australia; to Dr. W. Ramsay Smith, President of the Central Board of Health of the State of South Australia (and, under his instructions to Dr. F. Goldsmith, Govern-

1) Macmillan & Co., publishers, London; included also in the publications of the New Sydenham Society, London: pp. 238, 33 tables, 1 map.

2) Mitteilungen und Verhandlungen der Internationalen wissenschaftlichen Lepra-Konferenz zu Berlin, 1897. Vierte Abteilung. S. 162—72.

ment Medical Officer for the Northern Territory of South Australia); to Dr. D. Astley Gresswell, Chairman of the Board of Public Health, State of Victoria; and to Dr. B. Burnett Ham, Commissioner for Public Health, State of Queensland. As regards these States I have acted merely in an editorial capacity.

The scheme proposed by Professor O. von Petersen of Petersburgh has been followed as closely as possible; but as it has been drawn up with forms of government and modes of administration in view which differ from ours, some very slight modification of it has been found unavoidable. Thus the Commonwealth Constitution Act does not directly give the Commonwealth Parliament power to legislate for control of the public health, except in respect of the subsidiary department of Maritime Quarantine — which, nevertheless, is inextricably bound up with management of the public health in general. The federation is limited to certain specific subjects (which need not be here mentioned, but which include Customs, Maritime Quarantine, Posts and Telegraphs etc. etc.); in all other respects the several States continue to be self-governing under Parliamentary institutions. Each, therefore, has its own Statute-law for control of leprosy; and hence, although these laws are generally resemblant, it is necessary to quote each separately. Secondly, administration of the laws for control of leprosy is in every State entrusted to, or ultimately falls to, the central health authority, which is called the „Board of Health“, or the „Central Board of Health“. If, in some states, Local Boards (commonly referred to as Local Authorities, and most often identical with Municipal Councils) have duties under these laws, still in practice every such duty is discharged by them under supervision at least of the central health authority, oftener by officers of that authority acting directly; in this latter way all specially dangerous epidemic diseases, such as smallpox and plague, are safely managed. Hence it follows that there are not anywhere communal (municipal) rules for the management of leprosy. Thirdly, under the mode of government just described it is plain that all asylums for lepers must be, and they are, under direct control of the central health authority; consequently there are not any societies for the control of leprosy, or for ameliorating the lot of lepers.

Professor von Petersen's scheme as necessarily very slightly modified to suit Australian circumstances.

1. Statistics:
   a) According to official returns (Number of lepers officially recorded for the whole country?).
   b) Of lazarets (Number of the above in segregation?). (Form, Sex, Age.)
2. Measures taken to combat Leprosy.
   a) Rules and Regulations made by the Government.
      X. Statute-law (Acts of Parliament).
      Y. Regulations made by the Executive Government, which have the force of law.
      Z. Rules for the internal management of lazarets made by the Department of Government in charge.

b) Activity of Government bodies, Societies for combating leprosy, municipal bodies, &c. (this I venture to interpret „Efficiency of the law, and of its administration“).
   1. Number of lazarets.
   2. Number of beds.
   3. Number of admissions and discharges.
   4. Occupations of lepers in the lazarets.
   5. Transport of lepers to lazarets by railway and steamship.
3. Manner in which lepers are lodged in (general) hospitals.

The modifications, it will be observed, fall under heading 2, sub-heads (a) and (b). The former needs no explanation; as regards the latter I would observe that the law being entrusted (as will appear below) to the Public Health Departments of Government is carried out in respect of every case brought to notice.

Certain headings of this scheme can, in the case of Australia, be eliminated as superfluous, or collectively answered in this place. I (b), which I imagine has the meaning ascribed to it in parenthesis, can be eliminated; for all known lepers are in segregation. In New South Wales it is true one nerve case is at large (Table IV, No. 103) although, as is believed, in a quiescent stage; but two other patients who have been discharged were dismissed on the ground that they had recovered. Sub-head 4 can be answered here by the statement that lepers in lazarets are not occupied except in New South Wales, where their employment consists in small tasks of gardening and of repair of buildings, which are found for them merely in order to interest them, and to provide them with pocket money. Sub-head 5 has an administrative, and a scientific aspect. As regards administration, it need merely be said that advantage is taken of the best means of conveyance available under the circumstances of each case; these vary very much according to the locality from which the patient has to be transported. If the railway is used, a separate compartment is taken, which is afterwards disinfected; on a coasting steam-vessel a declared leper could not get a passage. As to its scientific aspect, it would appear that contagionists regard leprosy as being at the worst less easily communicated from the sick than is tuberculosis by the tuberculous; special precautions therefore seem to be unnecessary. This, at all events, is the view taken in New South Wales, where lepers are not lepers by law until the Board of Health, after the prescribed enquiry has issued its warrant for their detention. In a matter of grave importance, therefore, and one in which the primary notification is often made by gentlemen of whose proficiency in the diagnosis of leprosy nothing is certainly known, suspects are remitted to Sydney for observation. The heading 5 may be eliminated; lepers are not retained in general hospitals in Australia.

The detail of the several laws is given below; here may be concisely discussed the question of their general efficiency, which is indicated under heading 2, sub-head (b). But this subject must be subdivided into (a) formal or literal sufficiency of the law, and (b) its practical efficiency.

Formal sufficiency of the law. The important questions

appear to be (a) whether the law takes special cognisance of leprosy, (b) provides for notification of cases, (c) orders segregation of patients in lazarets or other places, (d) authorises their continued detention, (e) and directs the framing of rules for their control in segregation.

(a) Special cognisance of leprosy is taken by the laws of New South Wales, Queensland, Victoria, South Australia, and Western Australia; the two first-mentioned having special Acts which prescribe and regulate the control of leprosy, while in the laws of the remaining three the disease is mentioned by name. In South Australia, however, leprosy is classed by name with the infectious fevers, and thus is brought under general provisions designed for control of scarlet-fever, smallpox, &c. &c.

(b) Notification is provided for in all of these States in ways which, for all practical purposes, may perhaps be taken as identical, but with formal differences of greater or less importance. Thus they all provide for dual notification — that is to say, they all throw the duty of notifying on the head of the household as well as on the physician. In Queensland the requirement is that „when there is reason to believe that any person in any house or premises is suffering from leprosy“ the householder, and „when any case of leprosy or supposed leprosy“ comes under observation of any physician then he as well, shall immediately notify it; whereas the law of New South Wales merely requires the householder and the physician to notify the appearance of „any case of leprosy“. In the other three States the phraseology usually employed in speaking of the infectious fevers is used — householders and physicians are required to notify cases of them „forthwith on becoming aware that any person is so suffering“. Thus, as a matter of form at all events, a wider net is cast in Queensland than elsewhere; there the central health authority has opportunity provided for it by law of examining suspected cases and of deciding upon them. But I see no reason to think that this difference, though it makes for completeness, has any practical importance. The law to all intents and purposes is the same in all the States, and in my opinion is formally sufficient.

(c) As regards segregation of lepers, the laws of New South Wales, Queensland, Victoria, and Western Australia, specificially provide for this; while that of South Australia merely gives power to remove cases of the infectious fevers (under which leprosy is included by law in that State) to „any hospital, quarantine station, or place, when proper isolation is otherwise not possible“.

(d) Then, as regards power to detain lepers in segregation the law of New South Wales specifically directs that they shall be detained until released by order of the central health authority, and that of Queensland and of Western Australia until they are discharged by order of the Minister administering the Act; the Victorian law makes no special provision for release (but this is perhaps implied in the power granted by Parliament to the Governor-in-Council to make regulations for the safe custody of lepers in lazarets as well as in the power to segregate them); and in South Australia there is no provision, except such as may be implied in the power to segregate. But,

as already pointed out, this power is there granted in respect of the infectious fevers; so that it appears to me at least doubtful whether it applies at all to persons suffering from leprosy and, if it does apply to them, whether they could be legally detained for the indefinite term during which leprosy continues under a law which manifestly contemplates in the main the determinate periods during which the infectious fevers last. However, it will appear below that this difference also has probably no practical importance as regards efficiency.

(e) Lastly power to make Regulations for safe custody of lepers in lazarets is granted to the Governor-in-Council by Parliament in Queensland, New South Wales, Victoria, and Western Australia.

The essential points are therefore provided for by the law of all the States; and if this should seem not to be so clearly the case in South Australia as elsewhere it will be seen, during the discussion of its practical efficiency immediately below, that any defect could easily be supplied on occasion arising. It may be taken that the law is everywhere formally sufficient.

Practical efficiency of the law. The practical efficiency of domestic laws, such as these, depends primarily on public opinion, secondarily on the punctuality and impartiality of the authority to which they are entrusted. Now, as regards public opinion leprosy is greatly feared by the people; should defect of the law be revealed in relation to any particular case, there is no doubt that any action which might be thought necessary and which was not sufficiently provided for by law would be forthwith authorised by the Executive Government, and the approval of Parliament would be afterwards sought. Thus, were a case of leprosy to be met with in the State of Tasmania (where no case ever has been observed and where, consequently, there is now law for control of leprosy), I believe that no practical difficulty in dealing with it generally as provided by law in the other States would be met with. To the statement regarding fear of leprosy, however, there are exceptions. In Queensland and in New South Wales the fear exists in a high degree; but in South Australia, and in Western Australia, cases have been observed too seldom to have aroused it or, at all events, to have elicited any clear expression of it. In Victoria but little fear is felt for quite another reason. This is that although from the middle of last century onwards many cases have been observed in aliens and four in whites who were certainly (2) or most probably (2) infected abroad, leprosy never has attacked the whites in that State — a very remarkable and important fact which strongly contrasts with the behaviour of this disease in New South Wales. Still, I have no doubt that public opinion everywhere demands the segregation of observed lepers; and there is evidence of this even in Victoria, in the existence of a special section in the general Public Health Act which provides for its control by segregation. The indispensable foundation in public opinion for practical efficiency exists, then, in all the States; and it can be briefly added that in all the States central health authorities are punctual and impartial in carrying out the law in respect of every case of leprosy brought to notice.

We may therefore proceed to consider the practical efficiency of the law in confidence that it is everywhere carried out both in spirit and in letter. But before doing so I will recall the second recommendation of the Lepra-conferenz, Berlin, 1897. Australian laws, though enacted long before the date mentioned, permit its adoption; but I shall have to show, nevertheless, that it cannot be acted upon, and for reasons which this Conference may perhaps see fit to take into its consideration. That second recommendation, it will be remembered, ran as follows:

> 2. The system of obligatory notification, of observation and isolation, as carried out in Norway, is recommended to all nations with local self-government and a sufficient number of physicians.

What it is that is done in Norway, however, must be sought elsewhere. I take it from a letter by Dr. **Armauer Hansen** which was printed in the Journal of the Leprosy Investigation Committee, No. 2, pp. 65—66. After remarking that in Norway the poor in the country are often provided for by wandering from farm to farm for entertainment, so that it happened that lepers among them were thus entertained, and that this had been checked in so far as concerns the latter who, if they could not keep themselves, were obliged to enter an asylum, he described the law of 1885 as follows:

> This law gives the Sanitary Commission or Board of Health in each district the right to order a leper if he will live at home, to have his own room, at least his own bed; his clothes ought to be washed separately; to have his own eating-apparatus, spoon, fork, knife etc. If he cannot or will not conform to this regimen, he is obliged to enter an asylum.

To proceed, then; practical efficiency must be considered in relation to notification, segregation, and observation (homedwelling under supervision). As regards notification I must again subdivide the subject, although at risk of becoming tedious. In New South Wales and Queensland notifications are to be addressed to Police Magistrates etc. who are charged to inform the central health authority forthwith; in the other States to the Local Board (usually the municipal council) much as in Norway. In the first place, then, it is conceivable that local councils exercising their functions among neighbours, business connections, and even relatives might sometimes exhibit both inaction and partiality. This must happen in Norway more or less often, where it depends on the zeal of the district physician and on the opinion of the population — to which effect (when given) is given wholly by the local council — whether lepers are allowed to remain at home or are removed to an asylum. But in Australia all cases which come to any notice are also reported to the chief of police by his local officers, and by the former to the central health authority as a matter of routine; there incompleteness need not be feared on the score just adverted to. In the second place, completeness of notification is chiefly contingent on the proficiency of physicians in diagnosis. This is a matter of much greater practical importance. In Australia such proficiency is no more general than, as is well known, it is in many other

countries in which the disease is met with much more commonly. Cases of leprosy have to my knowledge occasionally gone unrecognised for so long, both in New South Wales and in Queensland, as to make it almost certain that at any particular time more must exist than have been reported. But on the other hand, although a glance at Table IV (for instance), where the duration of illness before segregation has been noted, shows that the diagnosis has often not been made as soon as must have been possible, yet it also furnishes good ground for judging that all cases do come to light at last. I conclude on this point, then, that notification is practically complete. I can add that I am not aware of any reason for supposing that there has ever been wilful concealment of cases.

As regards segregation I have no doubt that the law is everywhere efficient. Every observed case is segregated as soon as the diagnosis has been authoritatively confirmed by the central health authority. I take the opportunity of adding that great precautions are everywhere taken to avoid error and injustice.

As to practical efficiency of the law in respect to observation (home-dwelling), it must be said that it is quite inefficient, for a variety of reasons which I will endeavour to explain. Nevertheless, it is first to be noticed that the Acts of New South Wales and of Queensland not merely contemplate it, but specifically provide for it. Thus, in the former State the Board of Health is empowered „to order that such person (declared leper) be removed to and detained in such lazaret until released by order of the Board, or be isolated in such place and in such manner as the Board may direct . . . . . .“; it is thus made abundantly clear that Parliament had in mind occasional segregation in some place quite other than a general lazaret, namely, the patient's own house; and intended that well-to-do persons at all events should not be compelled to go to the general lazaret, but be lodged at their own choice and charges under conditions to be prescribed by the Board in view of the object of the law. And, as to the conditions, the Board actually has prescribed those in use in Norway; the Norwegian minimum („his own bed“), however, being excepted, partly because separate beds are the custom in this country with all but children and the married. Our minimum has perforce been fixed, therefore, at a separate room, table, and (here is a little advance on Norwegian rules) a separate lavatory, bath &c. In Queensland, also, the law contemplates segregation elsewhere than in the common lazaret; but there the conditions imposed by Regulations (see below) which have the force of law are such as betoken a different attitude on the subject of communicability, and one which, I imagine, would be approved by hardly any member of this Conference. It must be added that they were framed long before advent of the present Commissioner of Public Health. To these two States alone I intended to refer when I pointed out above that the law was inefficient as regards observation. There is no formal provision of the kind referred to in the law of Western Australia; but it must be remembered that there the disease has been observed so very rarely as to have rendered it unnecessary to consider this point of management seriously. In Victoria, too, there is no pro-

vision of this kind; but there also leprosy has never appeared to be a danger and, as I have elsewhere pointed out, the disease died down with the patients in whose persons it had been imported from abroad, before any measure of prevention had been taken; a noteworthy matter[1]). In South Australia, also, there is no provision for application of the Norwegian practice; but there, again, the disease has never been observed in the south, while in the Northern Territory it has been confined to Chinese and aboriginals, with a single exception — a native of the United States, of 13 years residence in the Territory.

Now in speaking of the reasons why the Norwegian plan is impracticable here, I wish it to be understood that I refer exclusively to my own State. But I think it desirable first to define my personal position and, as far as necessary, to differentiate it from my official position. It will be readily understood that as the presiding and executive member of the central health authority to which the Leprosy Act is entrusted, I have a clearly defined duty to perform. I may think the mère idée on which that law is based of doubful validity, and I can at all events safely assert that its validity has not been demonstrated. I can also, apain quite safely, express the opinion that a law which unavoidably entails the hardships on some persons which I shall presently have to describe is unjustifiable unless by a clearly-defined aetiology, a danger clearly seen to the grave, and a consequent, inescapable, necessity. But in my official capacity I may not, and I do not, allow these views to take effect. Control of leprosy is a matter, under one aspect, of medical police. As the law stands, so, as completely as possible, is it carried out.

The main difficulty in the way of practice of observation (home-dwelling) lies in the view of leprosy and of its communicability taken by the people. We have learned by repeated experiences that the presence of a home-dweller would not be tolerated, in any municipality at all events. It will be said, probably, that the views so betokened should be steadily opposed by the central health authority; and so they are. But Australia is not merely called a democratic country; it is one in which the people actually do govern themselves in the broadest sense. The class which furnishes the greater proportion of the cases met with among the whites is directly represented in Parliament by some of its members. Hence, on the one hand, we have a law which is based on the notion that lepra is maintained and diffused by communication with lepers, but which contains, on the other hand, those provisions, advocated by physicians of influence, which permit of home-dwelling. And here the real obstacle to exercise of that permission reveals itself. How can the dreadful alternative of imprisonment for life be justified to a people who are jealous of their freedom, with whom inviolability of the home is the datum of the social scheme, who are educated and intelligent though perhaps without special knowledge, and who are accustomed to use their reason and to act upon

1) To the printer's reader. Please insert a reference here to my paper „Epidemiology of leprosy, &c. &c".

2) With this statement the rules for internal management of the New South Wales lazarets, for which I am responsible, may be compared.

it, as long as home-dwelling is occasionally permitted, and apparently permitted for no scientific reason, but merely because some people happen to be a little better of than others? This is a task which, I admit, is quite beyond my powers.

I am not engaged in discussing the aetiology of leprosy, nor even its epidemiology. I would here be understood to speak as having assumed the rôle of political administrator. Yet in that imaginary capacity I may ask, what is the aetiology of a disease which can be efectually controlled by the simple expedient of providing every affected person with „his own bed“, and leaving him practically free in every other relation of life? We know very well that in the accurately known, demonstrated, danger which attaches to the phthisical, a separate bed is a precaution against one casual detail of communication only; and even then, though the analogy now commonly drawn between tuberculosis and leprosy is a tempting one, it must not be forgotten that it is an analogy only, and that the modes in which leprosy is maintained and diffused remain, as a matter of fact, entirely hidden. But, it may be said, „his own bed“ is not all that Norwegian practice requires; a separate table is also stipulated for, while the visits of inspection paid by district physicians furnish the latter with opportunity for giving advice, and for exhortations to follow it. Well, I leave it to those who have experience to say what they think all that is practically worth. What plausible reason can be alleged for submitting any leper who is not abjectly destitute (and to such persons I do not refer; the abjectly destitute who happen to be cancerous, or phthisical or leprous are properly and necessarily consigned to separate wards in charitable institutions, where they die peaceably) to imprisonment for life unless he can furnish „his own bed“? How was that minimum — that nothing — arrived at? I do not know; but in my assumed rôle of political administrator I easily perceive that it avoided a grave difficulty. Unless it had been adopted it would have been necessary to confine in lazarets an immense number of people who were far from being abjectly destitute, but who yet could not provide themselves with a separate room; and this no Government of a country where lepra had been an accustomed enemy from ancient times, and was wide-spread in the present, could face. But in Norway, it is asserted, the separate bed régime has proved successful. Then I ask once more for light on the aetiology of so mysterious a disease; and I ask for clearer proof than has yet been given that the ascertained diminution of leprosy in Norway has resulted from that régime and from it alone.

I would repeat that I am not now discussing the aetiology of leprosy. Speaking merely in my assumed rôle I may suppose that my professional advisers have recommended a certain course to me, namely, that which has for so long been followed in Norway. Thereupon I ask for reasons and, having been furnished with them, I proceed to scrutinise and to check them.

That leprosy diminished in Norway during the latter part of last century is an ascertained fact. After nearly fifty years of control there is still a good deal of disease left; however from 1856 onwards the

régime referred to continued to be the law, until in 1885 it was somewhat extended by law. These facts do not raise a presumption of cause and effect, but they do furnish ground for enquiring whether application of the régime was a cause or only an accompaniment of the observed diminution. In order to answer that enquiry, if answered it may be, other facts must be taken into consideration.

What has been the known course of leprosy in Norway? Beginning with the present day, there is now a moderate amount of the disease: in travelling backwards over the decades we become aware of a gradually increasing prevalence, until, between 1860 and 1850, and between the latter year and 1840, we see a great prevalence; from 1840 we note a diminishing prevalence again, until at beginning of the century there remains only so much as gave rise to no uneasiness and, indeed, attracted no attention. Of times immediately before that no view can be had: but on referring to the records we find that at some time or times extending as far back as the XIIIth century, there was a sufficient prevalence to fix the attention of the historian. So that we know of a noteworthy prevalence in the far past, of a very moderate prevalence at beginning of the century, of a gradual increase during the first three or four decades, of proportions which thereafter so increased as to attract public attention and ultimately to suggest enactment of a law; and then, in due course, of the approach of another time of slight prevalence. This, it further appears, is practically what has been observed in every other country of Christendom, at least as regards diminution; for in many the disease has died out, and in the rest has died down, either in the course of nature or at all events under influence of conditions which did not include any effectual, or nearly effectual system of segregation. What further test can be applied? Turn to the régime itself, and try to ascertain whether any tangible effects of it can be traced.

Still examining the matter in my assumed character, I think I perceive that the régime could not possibly have had the alleged effect, save in one respect. If the disease be maintained by communication with the sick, then removal of some of the latter to lazarets should have been beneficial. Possibly the result may be traceable in some diminution of the proportionate number of new cases. The absolute numbers cannot the utilised, because the question is whether the disease has slowly died down (as in other countries) or whether it has been suppressed. Reference must therefore be made to proportionate numbers: and ex hypothesi, the number of new cases arising in any year should be more or less exactly proportioned to the number of home-dwelling lepers. Hansen, indeed, has sought to prove the case for the régime in that very way: and necessarily its advodates must do so when they are challenged. Hansen chose the districts of Nordmoere und Sundmoere, in one of which the „home-dwellers" were more numerous than in the other, and showed that the number of new cases annually occurring was also greater in the former. He does not seem to have noticed that if his observed facts support this contention, incidentally they also go to prove the inefficiency of the home-dwelling scheme: but that is not a point on which I wish

to dwell just now. I have elsewhere attempted to elucidate this unavoidable question of proportionateness between the number of home-dwellers and the number of new cases annually arising, not by comparison of selected districts but by taking the official returns for the whole country. The result was the following:

Table showing by percentages the proportion borne by the number of new cases which arose in any year to the number of home-dwellers ascertained in the preceding year, from 1857 to 1885.

1857	9,1	1865	10,4	1872	7,6	1879	6,6
1858	8,8	1866	10,7	1873	7,8	1880	5,1
1859	10,4	1867	10,7	1874	8,6	1881	4,2
1860	9,8	1868	11,2	1875	8,6	1882	4,4
1861	10,0	1869	9,8	1876	6,5	1883	6,1
1862	10,1	1870	10,1	1877	7,2	1884	2,1
1863	9,8	1871	9,6	1878	7,8	1885	2,2
1864	10,5						

Thus there was an apparent proportionateness between home-dwellers and new cases during the first fifteen years, but this feature entirely disappeared during the latter fifteen years. I beg to be excused if I once more remark that absolute numbers are not in question, but proportionateness alone. In my assumed character of ultimately responsible political administrator, then, I feel obliged to remit the matter to my professional advisors, with the remark that these considerations appear to render the ground on which their recommendation was made too insecure for the purposes of practical legislation.

I proceed, therefore, to describe the results which attend in practice on the law of New South Wales. I consider the whites alone. With us, as elsewhere, leprosy chiefly attacks the poorer classes; it finds most of its victims among mechanics, the humbler tradesmen, labourers, and the like. These are very respectable people, who share ample and good food, who live in good cottages, and who maintain themselves in cleanliness with decency. But families are often large. Necessities are fully supplied, but there is little superfluity; and, most often, it is impossible to provide the patient with the separate room which (separate beds being already universal) represents the least measure of precaution which can be imposed. To the lazaret, therefore, all of this class are perforce consigned. But here, again as elsewhere, leprosy is far from sparing the well-to-do. These could easily furnish a separate room for themselves, often a separate house. But other circumstances then come into play which are no less inhibitory of home-dwelling than is poverty. Popular fear of the disease is such that in no populous neighbourhood would the presence of a declared leper be tolerated; and it has turned out to be impossible in the long run to keep cases secret. The conditions under which the patient must live attract attention; and if his disease be not known to be leprosy, that character is most likely to be attributed to it by neighbours. This has happened within my experience to invalids who lived eccentrically, but

who had not leprosy. The imputation of leprosy does not affect the patient alone; it reflects on all his family, and with results which are seriously damaging to it, if not ruinous. To the lazaret, then, all such patients also gravitate where, prudently, they have sometimes taken extraordinary pains to conceal their identity. There is small chance of release thence. Aliens are, if possible, repatriated; but it is very difficult to secure passages for them unless they can be certified to have recovered. But as for our own people they are there for life. Very rarely has a case of l. nervorum been seen to enter on a stationary stage which justified discharge.

Thus the nett result of attempting to adopt Norwegian practice in New South Wales is that children are separated from their parents, bread-winners are abruptly taken from their families, young husbands are separated from their wives, young wives from their husbands, and both of these latter from their young children. I am not speaking of what might happen; I refer to cases within my experience, and commonly within it. It may be replied that usual forms of illness often have similar results; and, in the case of the poor that they generally lead tho the later stages being passed through in separation from friends, since admission to a public hospital ultimately becomes unavoidable and is, indeed, the best way of smoothing the end. Well, that is true; illness is a misfortune which has to be borne as it best may. But in illness of usual kinds the sick themselves direct what shall be done. If poverty compels separation, either it is accepted with hope, or submitted to in the voluntary exercise of compassion for the household which has expended itself and its slender resources, and can no more. This is affliction.

How different is the case with leprosy! Persons wo are affected by this disease no more feel ill than do those who suffer, for instance, from eczema, at least until the later stages have been reached. Almost invariably they are following their usual avocations when they are taken, and often continue for long after their segregation physically competent to support themselves, an in possession, very often, of a degree of vigour which they themselves, at all events, do not differentiate from the normal. Under these circumstances the law steps in and seizes them, removes them from every association in which their lives have hithertho consisted, and confines them in strange, sad, company. If, at first, in they entertained an expectation of cure and of release, they soon learn from their seniors in isolation that they had very little ground indeed for it. Thus they are deprived of hope. Apparently — it may perhaps not be so in fact — apparently death must be the brightest point on their gloomy horizon. This is not affliction; this is hardship.

Manifestly the theme is one to tempt the eloquent; yet I doubt whether they could much enhance the force inherent in the bare facts. These are such, I repeat, as could be excused only by an unavoidable necessity, securely based on a clearly ascertained aetiology. I am of opinion that we have neither the one nor the other justification. We have apparent probabilities — but nature is full of surprises; wo draw analogies — and act upon them as though they were facts. The re-

sults to the afflicted are a certainty; the results as regards prevention, which is the object in view, are but a contingency. How justly did Herbert Spencer deplore the itch to be doing — something.

It has been remarked (Mitteilungen und Verhandlungen der internationalen wissenschaftlichen Lepra-Conferenz, Berlin 1897, III, S. 170) of opinions expressed by me that „it is remarkable that these views" Ital. (adverse to the opinion that leprosy is maintained and diffused by communication with lepers) „should be held by the Principal Medical Officer of a country which has enacted perhaps some of the most stringent laws extant against lepers". I would take this opportunity of pointing out that while there could be good ground for the first part of this remark only if I had drafted the law referred to, which was not the case, the Act is not as stringent as the writer supposed; I have already shown that it quite well admits of the Norwegian practice, and even seems to have been framed in view ot it. I will add — indeed it must be apparent — that I wish that practice could be carried out here, although not because I see reason to believe it could be effectual as a preventive. I will speak more explicitly. In the present state of knowlegde I believe the only legal enactment respecting leprosy which could be justified, is a measure to secure to competent observers full opportunity for observation. Let notification be compulsory; authorise supervision of patients; require members of the patients' househould to present themselves annually for survey as long as they continue in the country; make record and occasional review of the observed facts a statutory duty of central health authorities; but let him who has a home live and die in it, if he will. Take whatever steps are necessary to enable exact observation of the epidemiological facts; but defer action which entails life-long imprisonment and the breaking-up of homes, a) until the necessity for it shall have been unmistakably shown, and b) until the possibility of taking it effectually has been demonstrated (see the column „previous duration of illness", Table IV, below).

State of Tasmania.

The statement contained in the work referred to at first still holds good. Dr. J. C. S. Elkington has reported that no case of leprosy has been heard of in Tasmania during the ten years now under review, and that no law for control of this disease ever has been made. I may add, I think, that if any case were met with it would probably be dealt with as in the other States (see below) on authorithy of the Executive Government; the action taken would be subsequently confirmed by legislation.

State of Western Australia.

1. Statistics of leprosy. See Table I.
2. Measures taken to combat leprosy.
   a) Rules and Regulations made by Government.
   x) Statute law. In the Health Act, 1898, the following Section occurs: —

113. The Governor may from time to time by order published in the Government Gazette direct that any suitable place be set apart for the reception and medical treatment of lepers, and may make regulations for the safe custody of such lepers therein. The Central Board may, on the certificate of the Health Officer of a Local Board and any two legally qualified medical practitioners that any person is suffering from leprosy, and with the consent of the Local Board, direct that such person be removed to and detained in such quarantine station or place until released by order of the Minister; and any person who wilfully refuses or neglects to obey any such order of the Central Board, or escapes or attempts to escape from such quarantine station or place may, with such necessary force as the case may require be removed or brought back to such station or place. An order of the Central Board under this section may be addressed to such member of the police force or other person as the Central Board may consider expedient; and any person who disobeys or wilfully obstructs the execution of such order of the Board, or who trespasses on such station or place, or communicates or improperly interferes with any person detained therein, shall be guilty of an offence against this Act. (Penalties: not exceeding Lstrl. 20, or for a continuous offence not exceeding Lstr. 5 nor less than Lstr. 1 for each day during which the offence is continued).

But in addition to this spezial law regarding leprosy the Central Health Authority has power under the general provisions of the Act to declare what diseases are, for the purposes of any Act relating to the public health, included in the description „malignant infectious or contagious disease" &c., (Section 112) and the Governor can then make an Order (Section 110) which may apply to the whole State or to particular districts for management of such disease; the Order may provide for giving notice to the Central Health Authority of the occurrence of cases of the disease, and for entry at all times on premises. Many other matters may be regulated by such an Order, but those mentioned are of most importance in the present connection.

Y) Regulations made by the Executive Government. General Regulations were made 11th March, 1903. By the two first of them occupiers of premises wherein there is any case of infectious or contagious disease are required to notify it to the Local or District Board, or to the Central Board of Health. But prior to this, namely on 10th October, 1902, the Central Board of Health had made the following Order, which is at present in force:

For the purpose of preventing the spread of leprosy the Medical Officer of the Central Board may from time to time order and direct all persons deemed by the Medical Officer of Health of the Central Board or of any local or district Board to have been exposed to any infection to report themselves for examination to the Medical Officer of the nearest Local Board or District Board at such intervals and for such a period as the Medical Officer of the Central Board shall direct: and such Medical Officer of any Local Board or District Board shall, after examination of any such person or persons report to the Central Board as to the presence or otherwise of any signs of such disease.

Z) Departmental rules for management of asylums. None have been made.

1. Number of lazarets. One (see footnote to Table I.

2. Number of beds. One or two.
3. Number of admissions and discharges. Admissions, one; discharges, none. Remaining, one.

State of South Australia and its Northern Territory.

It should be observed that this State runs through the continent from the south to the north. The more important part of it lies to the south; Adelaide, the capital, being in S. Lat. 34° 55′ the chief town of the northern territory, Palmerston, situated on Port Darwin, lies in S. Lat. 13°, the intervening country is desert, but penetrated by a railway which runs about 146 miles south from Palmerston, and about 700 miles north from Adelaide. Leprosy has never been observed in the south, and in the north only among Chinese and aboriginals; with exception of one white, a native of the United States, of 11 years residence in the Northern Territory, where he was a teamster and labourer.

1. Statistics of leprosy. See Table II.
2. Measures taken to combat leprosy.
   a) Rules and Regulations made by Government.

X) Statute law. The Health Act, 1898, defines the term „infectious diseases“, therein used, as including „leprosy“. In Part VIII of the Act it is directed that when any inmate of any building is, or is supposed to be, suffering from any infectious disease the head of the family &c., and any medical practitioner attending on or called in to visit such inmate, shall so soon as they become aware that such inmate is suffering from any infectious disease, report the same to the Local Board, under a penalty for neglect not exceeding £ 5; and that the Local Board shall report it to the Central Board of Health. Local Boards are also required to appoint Officers of Health, and the latter are directed by general Regulations made by the Central Board under this Act to visit localities in which they hear of cases of infectious disease, examine into the circumstances, take necessary steps to prevent spread, and report to the Central Board. Then, should the Central Board receive a certificate from an Officer of Health or from any medical practitioner that infectious disease exists in any district, and that isolation is necessary to prevent the spread thereof, the Central Board may be authorised by an Order in Council to confine the patient to his premises and to prevent the ingress and egress to and from them of all persons. By Section 143 of the Act Local Boards are empowered to remove any person suffering from an infectious disease to any suitable hospital, quarantine station, or place, when proper isolation is otherwise not possible; and by Section 144 they are empowered to provide hospitals or temporary places for reception of persons suffering from infectious diseases. By Section 22 all the powers enjoyed by any Local Board are conferred on the Central Board and may be exercised by it with respect to the whole State. Lastly, detection of a leper on an incoming vessel could (as in every other State) be dealt with as an unforeseen emergency under the Quarantine Act, Section 7, and the Governor in Council might make any order

respecting the patient, or the ship, or both, which the Government might deem necessary.

Y) Regulations made by the Executive Government. None.

Z) Departmental rules for management of asylums. None.

1. Number of lazarets. One, in the Northern Territory. „A piece of land on the opposite side of the harbour (that is, from the town of Palmerston) has been assigned to lepers.“
2. Number of beds. No information.
3. Number of admissions and discharges. Admissions 17; discharged, ten (repatriated 5; dismissed to tribal territory 5). Remaining, none.

State of Victoria.

1. Statistics of leprosy. See Table III.
2. Measures taken to combat leprosy.

a) Rules and Regulations made by Government.

X) Statute law. During 1888 an amending Public Health Act was passed which contained the following provisions:

The Governor in Council may from time to time direct that the Middle Quarantine Station (at Point Nepean, Hobson's Bay) or other suitable place be set apart for the reception and medical treatment of lepers, and may make Regulations for the safe custody of lepers therein.

And then, secondly:

The Board (of Public Health) may, on certificate of the Health Officer of the (local) Council and any two legally qualified medical practitioners that any person is suffering from leprosy, and with consent of the (local) council, direct that such person be removed and detained in such quarantine station or place &c.

Immediately afterwards the Middle Quarantine Station was set apart for the reception of lepers. Then in 1890 an Act to Consolidate and Amend the Laws relating to the Public Health was passed; it continued the law just given above (Section 124), but it gave the Board power to declare what should be deemed to be infectious diseases, and gave it extended powers for preventing their spread. Thus Section 122 conferred power upon it to make regulations as to diseases, Section 123 to declare what diseases should be included under the term „infectious diseases“, and by Section 129 medical practitioners and heads of households were required to report cases to the Local Council within 24 hours of becoming aware that any inmate was so suffering, under a penalty not exceeding £ 50 for failure. Lastly, leprosy was declared by the Board to be an infectious disease during March, 1893.

Y). Regulations made by the Executive Government.

„The Public Health Act, 1888“ — Regulations under Section 8. At the Executive Council Chambers, Melbourne, the fifth day of February, 1889 Whereas the Governor in Council did by Order dated the eighth of January ultimo, and published in the Government Gazette, direct that the Middle Quarantine Station, viz., the huts at present occupied by certain Chinese lepers and their attendant, including the

land six hundred yards in every direction from the centre of the group of huts situated between the Quarantine Station proper and the Cattle Quarantine Station at Point Nepean, in the County of Mornington, in the Colony of Victoria, be set apart for the reception and medical treatment of lepers:

And Whereas it is expedient to make Regulations for the safe custody of such lepers therein: Now, therefore, His Excellency the Governor, with the advice of the Executive Council thereof, in accordance with the provisions of and in exercise of the powers conferred by Section 8 of the Public Health Act, 1888, doth hereby order as follows, that is to say:

1. All lepers detained at the said Middle Quarantine Station shall be safely kept by the attendant or attendants duly appointed for that purpose within the limits set out in the said first-mentioned Order, under the care, inspection, and supervision of the Medical Superintendent of the Quarantine Station for the time being.

2. All food, medicine, clothing, and other necessaries shall be obtained under the direction of the said Superintendent, and shall be conveyed to the said lepers by the said attendant or attendants, and no other person shall enter within the said limits without the authority of either the Minister, the Central Board of Health, or the said Superintendent.

3. A report of the condition of all lepers detained shall be furnished by the said Superintendent to the said Board quarterly, or at such other times as the Minister or the said Board may direct.

4. Nothing herein contained shall be taken to affect the power of any judge or justice to visit and examine the said Middle Quarantine Station at any reasonable time as he may see fit.

5. In the event of the death of any leper detained under the said Act and these Regulations, immediate notice thereof shall be given by the said Superintendent to the Coroner of the district, or in his absence to the nearest Justice of the Peace, and a report shall also beforthwith for warded to the said Board by the said Superintendent.

And the Honourable Charles Henry Pearson, for Her Majesty's Chief Secretary for Victoria, shall give the necessary directions herein accordingly.

(Signed) Rob. Wadsworth, Clerk of the Executive Council.

Z). Rules for the internal management of Lazarets. None have been made; internal arrangements are made by the Medical Superintendent of the Quarantine Station, who visits the lazaret at least once a week. All reasonable wishes of the very few patients who, at any one time, have been under detention, are met.

1. Number of lazarets. One, established on the reserve for purposes of maritime quarantine, at Point Nepean, Hobson's Bay.
2. Number of beds. A few.
3. Admissions and discharges. Admissions, 4; discharged (repatriated) 1; remaining, 1.

State of NewSouth Wales.

1. Statistics of leprosy. See Table IV.
2. Measures taken to combat leprosy.
   a) Rules and Regulations made by Government.

X). Statute Law. An Act „to provide for the notification of cases

of leprosy, for the detention and isolation of lepers, the appointment of lazarets, and for other purposes" was placed on the Statute-book in November, 1890. It was incorporated with the Public Health Act, by the Public Health Act (consolidation), 1902. It was not altered; but in course of consolidation its sections were separated from each other, and it is more convenient to quote it in its original form.

Leprosy Act, 1890: Be it enacted by the Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of New South Wales in Parliament assembled, and by the authority of the same, as follows:

1. This Act may be cited as the „Leprosy Act of 1890".

2. In this Act the expression:

„Board of Health" means Board of Health as constituted under the authority of the „Infectious Disease Supervision Act, 1881.

„Governor" means Governor with the advice of the Executive Council.

„House or Premises" means and includes any house, part of a house, room, ship, vessel, boat, tent, van, shed, or other structure.

„Legally qualified Medical Practitioner" means a legally qualified Medical Practitioner within the meaning of the Medical Practitioners Act of 1855, and any Act amending the same.

3. On the appearance of any case of Leprosy in any house or premises the householder or occupier of the said house or premises, and also the medical practitioner attending the case, shall immediately report in writing such case to the proper authorities in manner following, that is to say: — If the case occur within the Metropolitan Police District then the report of the case shall be made to the Secretary of the Board of Health, and if the case occur beyond the Metropolitan Police District than the report shall be made to the Officer in charge of the Police Station nearest to the said house or premises. If any person required by this section to report any such case shall fail to make such immediate report as hereinbefore required, such person shall be liable to a penalty of not less than ten nor more than fifty pounds.

4. (I). The Governor may, by Proclamation published in the Gazette, direct that any suitable place be set apart as a Lazaret for the reception and medical treatment of lepers, and may make regulations for the safe custody of such lepers therein.

(II). The Board of Health shall, upon report being made as aforesaid, or upon report made by any legally qualified medical practitioner, that any person is suffering from Leprosy, cause investigation by two or more legally qualified medical practitioners, and upon being satisfied that such person is suffering from that disease, may order that such person be removed to and detained in such Lazaret until released by order of the Board, or be isolated in such place and in such manner as the Board may direct; and any person so ordered who wilfully refuses or neglects forthwith to obey any such order or any directions given by the Board or escapes or attempts to escape from such Lazaret or place of isolation may with such necessary force as the case may require be removed or brought to any Lazaret or orther suitable place.

(III). Every such order shall be in writing, and shall be signed by the President, or Secretary, or any two members of the Board, and may be addressed to a member of the police force or other person as the Board of Health may consider

expedient; and any order so signed shall be a sufficient warrant to any member of the police force or such other person for arresting the person named or described therein, and for removing him or bringing him to any Lazaret or other place, and for taking all such steps and doing all such things as may be requisite to enforce the said order.

(IV). Any person who wilfully disobeys or obstructs the execution of, any such order, or who trespasses on any such Lazaret or other place, or communicates or improperly interferes with any person detained therein, shall be liable to a penalty of not less than ten nor more than twenty pounds.

(V). Every person who, prior to the passing of this Act, has been detained as a leper in the Coast Hospital at Little Bay shall be deemed to have been lawfully detained, and to be a leper detained within the meaning and for the purposes of this Section.

5. Any order purporting to be signed by the President, or Secretary, or any two members of the Board of Health shall in all proceedings be admissible without further proof as prima facie evidence that such order has been duly made in pursuance of this Act.

6. The Governor, upon the recommendation of the Board of Health, may make and issue regulations for the purpose of carrying this Act into effect; and such regulations shall be forthwith published in the Gazette. Any person, not being a leper, who shall wilfully disobey or act in violation of any such regulations, or who shall resist or wilfully obstruct any person in the lawful exercise of any of the powers conferred under this Act, or who shall, without lawful excuse, neglect or disobey any requirement made under the provisions of this Act, or shall neglect or refuse to obey any order or direction of the Board of Health made under this Act, within the time limited in that behalf by such order or direction, shall for every such offence be liable to a penalty not exceeding twenty pounds.

7. All proceedings for offences against this Act, or against any regulation made under this Act, may be had and taken in a summary way before any Stipendiary or Police Magistrate or any two Justices of the Peace, under and subject to the Acts in force for the time being regulating summary procedure before Justices. The amount of every penalty inflicted under this Act or any such regulation together with costs, may be recovered and enforced by distress and sale of the goods and chattels of the person ordered to pay the same, and in default of sufficient distress such person shall be liable to be imprisoned with or without hard labour for any term not exceeding six months, unless such penalty and costs be sooner paid.

Y) Regulations made by the Executive Government. It has not become necessary to make Regulations.

Z). Departmental rules for internal management of asylums.

Department of Public Health, New South Wales. Rules for management of the Lazarets, Coast Hospital, Little Bay, Sydney.

*** These Rules which have been framed as for the Lazaret for men are also to be observed at the Lazaret for women as closely as possible.

1. Superintendence and organisation.

1. The Medical Superintendent of the Coast Hospital shall be generally responsible for good management of the Lazarets, and for medical treatment of the patients therein. He shall visit them at least three times a week, and at one visit in each week he shall be accompanied by the Matron; he shall inspect the food at

meal-times at least once a week. He shall take care that the patients are not in any way hindered from conversing with him personally, and in private if they so desire; he shall give consideration to any complaints or requests which they may make to him. He shall see that they are treated kindly, and in case of disobedience he shall take care that they are managed with as much forbearance as maintenance of discipline and the interests of other inmates, reasonably permit. He shall by occasional inspection secure the punctual keeping of all books and records. He shall sign the gate-book at each of his visits. He shall forthwith report to the Secretary of the Department any unusual occurrence, and any matter which he may judge requires the personal ruling or interference of the President.

2. The Matron of the Coast Hospital shall, under direction of the Medical Superintendent, superintend the nursing staff, including the male-attendants and the housekeeper, and shall give such instructions in relation to nursing, housekeeping, general cleanliness of quarters, and clothing of the inmates as to her may appear necessary. She shall sign the gate-book, and shall mention to the Medical Superintendent any matter coming to her notice to which his attention should be called.

3. The Chief Attendant at the Lazaret for men shall be responsible for custody of the patients; for their due observance of the rules which apply to them; for cleanliness of the grounds and of the quarters; and for general good order of the establishment. He shall carry out the instructions of the Medical Staff as regards treatment, and of the Matron as regards nursing, cleansing and housekeeping; and he shall see that patients receive medicines and dressings at the proper times. He will take care that patients bathe regularly, keep themselves clean and tidy, change underclothing regularly, and receive new outer clothing as dirt and disrepair render necessary. He will at all times treat inmates with kindness and forbearance, but will maintain order, and whenever there is need will report to the Medical Superintendent. He will apportion their work to the staff under him. He will requisition, keep, and issue such stores as are kept at the Lazaret, see that all books and records in his charge are regularly and carefully kept, and especially that the names of all visitors to the Lazaret and of the patients they visit are on each occasion entered in the gate-book. He will prevent entry to the enclosure of all except members of the staff on duty and specially authorised visitors.

4. The First Attendant at the Lazaret for women shall act as housekeeper at the Lazaret for men, and shall visit it daily as often as may be necessary. She shall be responsible for all matters usually comprised under housekeeping; she shall regularly inspect quarters, and shall supervise the comfort and general well-being of the patients. She shall be present at meal-times and shall report whether the food is of good quality, well cooked, and properly served.

5. The Second Attendant at the Lazaret for women shall carry out such duties at both Lazarets as may be directed by the First Attendant.

6. Attendants on duty at the Lazaret for men shall carry out the instructions of the Chief Attendant in charge of it.

7. The Lazaret staffs shall be governed by the general Rules of the Coast Hospital, except in as far as they are repugnant to or inconsistent with these Rules.

II. Patients.

8. Patients will obey the general rules for management of the Lazarets and submit to the directions of the Chief Attendant. In case of dispute they will appeal to the Medical Superintendent.

9. They will pay the utmost attention to cleanliness of person and of their quarters. They will bathe not less than three times a week, wash twice daily at least, keep their dress clean and tidy, generally keep their quarters, verandas, and adjacent grounds clean and tidy as may from time to time be directed by the Chief Attendant, wash their own bed and body linen, and assist in special quarterly cleansing of their own quarters.

10. Those who desire special articles of clothing, food, drink, &c. must inform the Chief Attendant before 10 a. m. each day.

11. They are forbidden to have communication with any person except fellow patients, attendants, and authorised visitors.

12. They shall not leave the enclosure without permission of the Chief Attendant on any pretext.

13. They will rise not later than 7 a. m., and retire at 9 p. m.; all lights must be out at 9,30 p. m.

14. The hours for meals shall be the following — breakfast, 7,45 a. m., dinner, 12,45 p. m., supper 5 p. m.

15. Meals shall be taken in the general dining-room. All patients must appear at table without fail, and at the proper hours.

16. Patients receiving medicines or requiring dressings shall attend at the dispensary at 10 a. m., 2 p. m., and 6 p. m. daily.

*** The Chief Attendant has power temporarily to exempt any patient from any of the Rules 8 to 16 for sufficient cause, but shall report exemptions granted by him to the Medical Superintendent. The Medical Superintendent may grant exemptions at and for such times as may seem necessary to him, the exemptions to be recorded.

17. No patient shall throw poultices, dressings, &c. into the waterclosets or sinks or gullies, or elsewhere than into the receptacles provided for the purpose.

18. Patients shall take care of their clothes and of the property of the institution, and shall see that tools, paint, &c. entrusted to them are not injured or wasted, and are returned to store at the end of each day.

19. Work in connection with maintenance of the institution buildings, and improvement of the grounds will, when possible, and subject to general good behaviour, be assigned to such patients as are competent and willing to undertake it, for which a sum not exceeding one shilling a day may be paid on recommendation of the Medical Superintendent.

20. Patients may not keep animals (dogs, cats, birds, etc.) except by special permission given only on the understanding that it may be withdrawn at any time, and that if withdrawn the animal or animals shall be forthwith destroyed.

21. They shall not leave the enclosure without permission on any pretext; but permission to go to the shore between the boathouse and the line of the northern boundary fence of the Coast Hospital grounds, to the land on the sea side of the road between the bridge and the enclosure, or to the land inside the Coast Hospital fence to the north of the enclosure, may be given by the Chief Attendant.

22. They must receive visitors in the visitors room, outside the gates, or in such part of the grounds mentioned in the preceding Rule 21, as the Chief Attendant may indicate; they may not take visitors into the enclosure except by special permission, on each occasion asked and granted by the Medical Superintendent.

23. They are forbidden to give or promise any gratuity in money or in kind to any officer of the Government.

III. Visitors.

24. Visitors may be received in ordinary between the hours of 2 and 5 p. m. daily; but Ministers of Religion and legal advisers may be received at any time on application to the Medical Superintendent.

25. None but relatives shall, as a general rule, be permitted to visit patients.

*** The Medical Superintendent may authorise such departure from the above rules 24 and 25 as circumstances may in his judgment render necessary or advisable from time to time in particular cases.

26. Visitors shall first give their names to the Attendant-in-Charge, together with the name of the patient they desire to see.

27. Their names will be communicated to the patient who will be asked whether he desires to see them.

28. They may not remain more than half an hour without special permission.

29. They shall not enter the enclosure, but shall wait in the Visitors', Room until the patient is brought to them by the Attendant-in-Charge.

30. Visitors shall leave when requested to do so by the Attendant-in-Charge.

31. They shall not introduce either alcoholic drinks (spirits, wine, beer, etc.) or narcotic drugs (opium etc.). Disregard of this rule will lead to their exclusion for the future.

32. They may introduce provisions, fruit, clothing, and the like things, but must hand them to the Attendant-in-Charge who will, after noting them, deliver them to the patient, subject to directions by the Medical Superintendent. If sent by carrier, &c. they must be addressed to the Medical Superintendent for such and such a patient. Should any article so brought or sent be considered unsuitable to the patient in his then condition, it will be returned to the sender.

33. They may not remove any article from the Lazaret which has been in possession of a patient. They are requested to wash their hands after visiting, and before leaving the institution.

34. They may not visit at times when in opinion of the Medical Superintendent the patient's condition is likely to be aggravated thereby; and should patients appear depressed after seeing any particular visitor it may become necessary to cause the latter to intermit his visits for a time. Care should be taken to converse cheerfully with patients.

35. They are forbidden to offer any gratuity in money or in kind to any officer of the Government.

IV. General and Staff.

36. A gate-book shall be kept in charge of the Chief Attendant who shall enter in it the names of all visitors to patients before the patient is called, and shall enter the name of the patient visited, together with the date. Members of the Medical staff on duty at the Lazaret, the Matron, and Ministers of Religion, shall sign it at each visit, but members of the Lazaret staff, and members of the Coast Hospital staff (with the above-mentioned exceptions) when visiting on duty, need not sign it.

37. A Case-book schall be kept in which the history of each patient, his treatment, and progress shall be entered.

38. Medicines etc. are to be kept in charge by the Chief Attendant and administered by him at the prescribed times. In case of refusal to accept the treatment ordered he will note it in the case-book, and will draw the attention of the Medical Superintendent to the entry.

39. Ordinary daily bathing may be at hours from time to time prescribed by the Medical Superintendent with reference to season, wishes of patients as far as possible, and general convenience of the management. The Chief Attendant will note failure to bathe regularly and will draw the Medical Superintendent's attention to patients who avoid bathing. Remedial baths will be taken at such times as the Medical Superintendent may direct.

40. Dressings, medicines etc. shall be given to patients able to attend at the dispensary at 10 a.m., 2 p.m., and 6 p.m. daily; patients exempted from attendance at the dispensary shall be attended at their own quarters immediately afterwards.

41. The bed-linen, shirt, night-clothes and under-clothing of patients shall be changed once a week, and as much oftener as the patient's condition may render necessary, or as shall be ordered by the Matron. In judging of necessity for change of external clothing regard shall be had to dirtiness as well as wear. External clothing shall be made of washable material as far as possible.

42. In addition to daily and weekly cleansing of quarters there shall be a more thorough cleansing etc. of them once in three months. Washable surfaces shall then be freely served with a solution of miscible carbolic at a strength of 5 per cent, and subsequently scrubbed.

43. Articles once taken into use at the Lazaret shall not issue therefrom to the Coast Hospital or elsewhere. Damaged or disused articles shall be reported for survey to the Matron who will recommend their destruction or further use as she may think fit. Such recommendations are to be regularly recorded and initialled by the Matron in the condemned-stores book. Actual disposal shall be directed by the Medical Superintendent by note made in the same book.

44. The Chief Attendant shall keep a condemned store, and a book in which worn-out stores shall be placed and entered as they are discarded; he shall report them to the Matron for survey once in three months at least.

45. Patients will as far as possible assist in washing their own bed and body linen; the Attendants at the Lazarets for men and for women respectively will complete it as may be necessary.

46. A member of the staff will be present at all meals.

47. Care is to be taken that all patients not exempted by the Medical Superintendent for illness appear punctually at meal-times and the Chief Attendant is to be informed at once of the unauthorised absence of any patient.

48. Rules for management of the library, recreation and billiard room, shall be made by the Medical Superintendent, and so posted that patients can make themselves acquainted with them. The Chief Attendant will be responsible for observance of them, and for careful use of the stock. Books when worn out are to be dealt with under Rules 43 and 44.

49. The Chief Attendant shall requisition the Coast Hospital for stores daily or weekly (except clothing) as the case may require and they shall be issued to him under Coast Hospital rules.

50. Clothing will be supplied to the Lazaret direct, and will be stored by the Chief Attendant who will be furnished with and will keep the requisite book.

51. The meal hours for the staff shall be 8 a.m., 1 p.m., and 5,15 p.m.

52. When visitors call, the Chief Attendant shall enquire of the patient whether he wishes to see them, unless they are well known to him.

53. Visitors to patients of the opposite sex shall be kept under unobtrusive surveillance during their stay, unless in the case of parents and children, or brothers and sisters.

54. The approaching death of all patients, as well as the fact of decease, ar to be promptly communicated to the Secretary to the Department by the Medica Superintendent, and instructions awaited.

Diet scale for European patients in the Leper Lazaret.

Item	Quantity	Unit	Period
Meat (uncooked)	1	lbs.	daily
Bread	1	„	„
Biscuits (Soda or coffee)	1/2	„	„
Potatoes	1	„	„
Vegetables	1/2	„	„
Milk	1/2	pint	„
Butter	1	oz.	„
Fish, fresh	1/2	lb.	weekly
Bacon	1/4	„	„
Sugar	1 1/2	„	„
Tea	6	oz.	„
Rice	1	lb.	„
Sago or Tapioca	1/4	„	„
Flour for Scones	1	„	„
Jam or honey	1	„	„
Eggs	7	„	„
Fruit, cooking	1/2	„	„
Fruit, Table	1	„	„
Salads in season	Twice a week		

Pork or lamb may be substituted for meat on Sundays.

Tinned meat or fish . . 1 lb. monthly

Dried fruit, extra milk or eggs for puddings, condiments an pickles, as required.

Tobacco, jelly, cocoa, coffee, and other extras will be orderec by the Medical Superintendent as may be necessary.

Diet scale for Chinese patients at the Leper Lazaret.

Item	Quantity	Unit	Period
Meat or pork (uncooked)	1	lb.	daily
Bread	1	„	„
Biscuits, soda or coffee	1/2	„	„
Potatoes	1	„	„
Vegetables	1/2	„	„
Milk	1/2	pint	„
Butter	4	oz.	„
Fish, fresh	1/2	lb.	weekly
Bacon	1/2	„	„
Sugar	1	„	„
Tea	4	oz.	„
Rice	7	lbs.	„
Flour	1	„	„
Eggs	3	„	„
Fruit, cooking	1/2	lb.	„
Fruit, table	1	„	„
Salads in Season	Twice a week		

Pickles and condiments	. As required
Tinned meat or fish . .	1 lb. monthly

Tabacco, opium and other extras will be ordered by the Medical Superintendent as may be necessary.

Diet scale for Attendants at the Leper Lazaret.

Meat (uncooked) . . .	1½	lbs.	daily
Bread	1½	"	"
Potatoes	1	"	"
Vegetables	½	"	"
Milk	½	pint	"
Butter	½	lb.	weekly
Fish, fresh	½	"	"
Bacon	¼	"	"
Sugar	1½	"	"
Tea	6	oz.	"
Cheese	½	lb.	"
Rice or sago	1	"	"
Flour	1	"	"
Jam or honey	1	"	"
Eggs	5	"	"
Fruit, cooking	½	"	"
Fruit, table	1	"	"
Salads in season . . .	Twice a week		
Tinned meats or fish . .	1	lb.	monthly

Additional allowance of ½ pint of milk for puddings three times a week.

Pickles, dried fruit and condiments as required.

1. There are two lazarets, for men and for women respectively. For convenience of management the lazarets are established in the grounds of the Coast Hospital (338 beds) at Little Bay, about 9 miles from Sydney with which they are connected by tram. That for men is situated in an unfrequented part of the hospital reserve, being connected with the general hospital buildings by a special road about 400 yards long; but that for women is quite close to some of the general wards. Both stand within their own enclosing fence; on the womens' side the entrance-gate is kept locked, on the men's side the staff-quarters are just outside the entrance-gate, and here is also the visitors' room. At both the buildings are of wood and iron, very well-built; patients' quarters consist of cottages with verandas which comprise two separate quarters of two rooms each — a bed-room and a sitting-room. Two rooms are assigned to each white patient, and one to each coloured patient as far as possible; but when there is pressure two coloured patients share one bed-room together. On the women's side the arrangement is the same. There are on that side two women-attendants, one of whom has also regular duties at the male lazaret; the number of women-patients is usually one or two only, and with a single exception they have always been whites. On the men's side the number of attendants is three, and there is a cook.

The annual cost per occupied bed has varied with the number of inmates; and this, during the 14 years which have elapsed since establishment of the lazarets has varied between 40 and 11 which are the numbers which remained at the end of the year. The cost also has varied between £ 53.3. 0d. and £ 154. 0s. 3d per occupied bed. The rules above given will enable any reader accustomed to institution management to learn as much of the organisation and conduct of the lazarets as has interest; it is only necessary to explain that the rules by which all but duly authorised visitors are excluded have been made with a view to prevent the merely curious from entering, and to prevent also unwelcome acquaintences from intruding on patients. As a matter of fact any person having any legitimate reason for visiting is furnished with an order of admission on application at the Department of Public Health, by which the Coast Hospital, as well as the lazarets, are controlled. The lazarets are also freely open to physicians, medical students at the University, etc. etc., who wish to study the disease.

2. Number of beds. The design is to allow each coloured patient one room, and each white a bed-room and sitting-room. The number which can be accommodated on these lines is Men: coloured, 12, white, 8. Women, white, 4. But at times two coloured patients have occupied one room, and whites have rarely been obliged to put up with one room apiece. Thus for a short time (prior to the date at which Table IV begins) as many as 44 patients were accommodated at one time.

3. Number of admissions and discharges. Admissions, 39; discharges, 7 (repatriated, 5; stationary or recovered and discharged to home, 2). Remaining, 16.

State of Queensland.

1. Statistics of leprosy. See Table V.
2. Measures taken to combat leprosy.

a) Rules and Regulations made by Government.

X). Statute law. An Act „to provide for the treatment of leprosy and the detention and isolation of lepers“ was placed on the Statute-book in July, 1892. It runs as follows: —

Be it enacted by the Queen's Most Excellent Majesty, by and with the advice and consent of the Legislative Council and Legislative Assembly of Queensland in Parliament assembled, and by the authority of the same, as follows:

1. This Act may be cited as „The Leprosy Act of 1892“.
2. In this Act.

The term „Minister“ means the Colonial Secretary or other Minister charged with the administration of „The Health Act of 1884“.

The term „Central Board of Health“ means the Central Board of Health constituted under that Act.

The term „House or Premises“ means and includes any house, part of a house, room, ship, vessel, boat, tent, van, shed, or other structure.

The term „Medical Practitioner“ means a Medical Practitioner legally qualified within the meaning of the „Medical Act of 1867“.

3. The Governor in Council may, by Proclamation, appoint any place to be a Lazaret for the reception and medical treatment of Lepers.

4. When there is reason to believe that any person in any house or premises is suffering from leprosy, the householder or occupier of the house or premises shall immediately report the case, in writing, to the nearest Police Magistrate, who shall forthwith forward the report to the Minister, and a copy thereof to the Central Board of Health.

And when any case of leprosy or supposed leprosy comes under the observation of a medical practitioner, he shall forthwith report the case, in writing, to the nearest Police Magistrate, who shall forthwirth forward the report to the Minister, and a copy there of to the Central Board of Health.

If any person by this section required to make a report fails to do so as hereby required, he shall be liable to a penalty not exceeding one hundred pounds.

5. The Minister shall, upon report being made to him that any person is suffering from Leprosy, cause investigation to be made by one or more medical practitioners, and upon beeing satisfied that the person is suffering from that disease, may, by order under his hand, direct that he be removed to and detained in a Lazaret.

If any person so ordered to be removed and detained wilfully refuses to obey the order, or escapes or attempts to escape from a Lazaret or from the custody of the person charged with his removal, he may, with such necessary force as the case may require, be removed and brought to or retaken brought back to, the Lazaret.

6. All Lepers so detained shall be safely kept by the attendant or attendants duly appointed for that purpose within the limits of the Lazaret, and under the care, inspection, and supervision of a medical officer appointed for that purpose, and all food, medicine, clothing, and other necessaries shall be obtained under the direction of such medical officer, and shall be conveyed to the Lepers by such attendant or attendants, and no other person shall enter within the limits of the Lazaret without the authority of the Minister or the medical officer.

7. A report upon the condition of all Lepers detained in a Lazaret shall be furnished by the medical officer to the Minister and to the Central Board of Health quarterly, or at such other times as the Minister may direct. In the event of the death of a Leper detained in a Lazaret notice of the death shall be given forthwith by the Medical Officer to the nearest Police Magistrate, and a report of the death shall also be forthwith forwarded by the medical officer to the Minister and to the Central Board of Health.

8. If it is proved to the satisfaction of the Minister that a person detained in a Lazaret, or a person ordered to be removed to a Lazaret, is not suffering from leprosy, the Minister may, by order under his hand, direct him to be discharged from custody.

9. Any person who wilfully disobeys, or obstructs the execution of, an order made under this Act, or who trespasses within the limits of a Lazaret, or communicates or improperly interferes with any person detained therein, shall be liable to a penalty not exceeding twenty pounds and not less than ten pounds.

10. Every person who, before the passing of this Act, has been detained by the authority of the Minister as a Leper in any place appointed for that purpose by the Minister, shall be deemed to have been lawfully detained.

11. When a person who is suffering from leprosy has sufficient means to provide for his proper maintenance and attendance by a medical practitioner, the

Governor in Council may direct that instead of removing him to a Lazaret he shall be removed to some place to be specially appointed by the Governor in Council for that purpose, and be there detained under such supervision and treatment as the Governor in Council may direct. All the provisions of this Act relating to Lazarets shall apply to every place in which a person suffering from leprosy is ordered to be so detained.

12. Any document purporting to be an order signed by the Minister under the Authority ot this Act shall in all proceedings be admissible without further proof as prima facie evidence that such order was duly made in pursuance of this Act.

13. The Governor, upon the recommendation of the Central Board of Health, may make regulations for the purpose of carrying this Act into effect; and such regulations shall be published in the Gazette.

Any person who wilfully disobeys or acts in violation of the Regulations, or who resists or wilfully obstructs any person in the lawful exercise of any authority conferred by this Act, or who, without lawful excuse, neglects or disobeys an order made under the provisions of this Act, shall be liable to a penalty not exceeding twenty pounds.

(Y). Regulations made by the Executive Government. The following Regulations were made at Brisbane, 2nd December, 1897;

Regulations for the prevention of spread of leprosy. Home Secretary's Office. Brisbane, 2nd December 1897. Leprosy Act, 1892.

His Excellency the Governor, with the advice of the Executive Council, has been pleased to make the following Regulations for the purpose of carrying into effect "The Leprosy Act of 1892." Horace Tozer.

Regulations.

As to Lazarets proclaimed under section 3 of the Act.

1. If the place proclaimed by the Governor in Council under Section 3 of the Act to be a Lazaret is not completely isolated, and is within a distance of one mile from any town, the houses, buildings, premises, and appurtenances thereto, in occupation or in use by the lepers or attendants, shall be securely enclosed together within a fence from the surrounding neighbourhood.

Investigation of reported cases of leprosy.

2. When any householder or occupier of any house or premises shall have reported that there is reason to believe that a person in such house or premises is suffering from leprosy, or when any medical practitioner shall have reported that any case of leprosy or supposed leprosy has come under his observation, one or more medical practitioners, besides the medical practitioner so reporting, shall forthwith be appointed to investigate the case reported. The medical practitioners so appointed shall make a joint investigation, and shall report thereon to the Minister.

3. The Minister, upon the recommendation, in writing, of any one or more of the medical practitioners appointed to investigate the case, may declare the house or premises in which any such investigation is being made to be a lazaret during the period of the required investigation, and all regulations hereby made applying to lazarets shall apply to such house or premises.

Treatment of dressings and clothing used by lepers in Lazarets.

4. All dressings used upon the lepers shall be burned by the attendant immediately on removal.

5. All clothing that shall have been in use by or upon any leper or any attendant and which shall be cast off shall be immediately burned.

6. The water used by the lepers or attendants in charge for washing themselves, or for bathing in, or for the purpose of washing any clothing or material used by them, shall be disposed of as soon as possible after it has been used.

7. All clothing used by any leper or attendant in charge and intended to be washed or otherwise cleansed shall, immediately on its removal from the person, be disinfected by being steeped in a solution of corrosive sublimate, and shall be washed or cleansed as soon as possible after removal.

8. All excreta, if there shall be convenience for so doing, shall be burned. Where no conveniences exist, it shall in all cases be disinfected with corrosive sublimate, and shall be removed daily.

Detention in places not proclaimed lazarets.

9. A person who is suffering from leprosy and is detained, as provided by section 11 of the Act, in a place not proclaimed a lazaret must provide himself with an attendant or attendants, to be approved of by the medical practitioner in charge of the case and the Minister. Such attendant or attendants must reside on the premises, and the person suffering from leprosy shall not at any time be left unattended. When there is one attendant only, he or she shall not leave the premises or attendance on the patient without leave given by the medical practitioner in charge; and the attendant must, in case leave be given, provide a substitute to be approved of by the medical practitioner in charge. A record of the time of absence, purposes of absence, places and persons visited by the attendant during such absence shall be entered in a book kept for the purpose, and the entry shall be signed by the attendant and the medical practitioner. The medical practitioner shall have sole discretion as to granting such permission or limiting it as he shall think proper.

10. No person suffering from leprosy shall be allowed to remain or be detained in any place not proclaimed a lazaret unless each and all of the following conditions and rules are observed:

1. A separate and detached room or rooms shall be provided for the patient for the purpose of eating and sleeping in. No other room or portion of the premises or house shall be used for these purposes. The room or rooms so used shall at no time be used or entered upon by any other person than the attendant or attendants and the medical practitioner in charge, except by the permission of the medical practitioner, who shall specify the purposes, and may at his discretion limit the time and conditions of such entry:
2. A separate bath-room and earth-closet shall be provided for the patient, and shall not be used by any other person;
3. A separate bath-room and earth-closet shall be provided for the attendant or attendants;
4. The water used by the patient or his attendants for the purpose of washing himself or themselves, or for bathing in, or for any other cleansing purpose, shall be disinfected with quicklime before being disposed of:
5. All eating apparatus and other necessaries for table use by the patient shall be kept separate at all times from those used by any other person. All necessary cleansing in connection therewith shall be done separately;
6. All clothing used by or upon the patient, and intended to be washed or otherwise cleansed, shall immediately on its removal be steeped in water

disinfected with a solution of corrosive sublimate, and shall immediately afterwards be washed and exposed to dry. All blankets, sheets, and other furnishings in and upon the bed used by the patient, and intended to be washed or otherwise cleansed, shall be similarly dealt with;

7. All excreta shall be immediately disinfected and removed. The earth-closet shall be cleansed daily and disinfected as directed by the medical practitioner in charge.

11. All regulations made hereby, or which shall hereafter be made with reference to lazarets, shall apply to every place in which persons suffering from leprosy are detained as provided for by section 11 of the Act.

12. Any breach of any of these Regulations by the person so detained shall be immediately reported, in writing, to the medical practitioner by the attendant in charge who shall have observed it. He shall, immediately on receipt of such report, investigate into the matter so reported, and shall report the circumstances to the Minister, with such comments thereon as he shall deem it advisable to make.

13. The attendant or attendants shall be subject to the control of the medical practitioner in charge; he shall have the power of suspending any attendant committing any breach of his duties or these Regulations, or who, he shall have reason to believe, has committed any such breach. He shall have the power of appointing a substitute during such suspension, and shall report the circumstances of such suspension, in writing, to the Minister.

14. The medical officer appointed for the purposes of this Act, or any other medical practitioner appointed, shall at least once in every month visit the place in which any leper is detained, as provided by section 11 of the Act, and shall report thereon generally to the Minister.

15. The Minister, upon being satisfied that any breach of these Regulations has been committed by the patient or attendant or attendants, or by the medical practitioner in charge, may order the removal of the patient to a lazaret.

16. The minister may order the removal of the patient to a lazaret if the disease shall have reached the ulcerative stage, or at any other time he shall think it expedient so to do.

Table

Showing all cases recorded in the State of

Returned by the President of the Central

Consecutive No. See „A History, etc.".	Name.	Sex.	Age.	Race or Nationality.	Occupation.	Form.
1902 3	J. H.	M	67	Irish	Labourer.	T

Note on case 3. This was the first observed instance of leprosy in a white in this State. Dr. Ernest Black has furnished the following particulars: The patient was a native of Ireland, male, aged 67 years; he had immigrated to Western Australia in 1847 (whether direct from Ireland or otherwise does not appear). He had been employed as a street-sweeper by the municipal council of Perth since 1901: and he lived at Guildford, a place about 8 miles from Perth, whence his case was notified by the District Medical Officer. He was transferred to the place used

Burial of deceased lepers and disposal of effects.

17. The bodies of all deceased lepers shall, within a period of twenty-four hours after death, be buried with quicklime.

18. All bedding, clothing, and all utensils used by the deceased, shall immediately after his death be destroyed by fire.

Z) Rules for internal management of lazarets. None hare been made.

1. Number of asylums. Two. One, to which white patients are sent, is situated on Stradbroke Island, Moreton Bay, and is in S. Lat. 28 E. Long. 154°, at the mouth of the Brisbane River, and about 40 miles from the capital. The other, to which coloured patients are sent, is situated on Friday Island (see photograph) which is one of that group in Torres Straits commonly referred to collectively as „Thursday Island", and lies in S. Lat. 10,5° E. Long. 142°. The lazaret on Stradbroke Island is placed about a mile from Dunwich, an extensive asylum for the poor; it is under management of the Medical Superintendent of the asylum, under direction of the Commissioner of Public Health. It has a staff which consists of a caretaker, a matron, a nurse, a cook, and 2 assistants; there are also a laundryman, a messenger, and labourers. It is beautifully situated near the shore and is complete in itself; the buildings are substantial (see photograph); as far as possible each inmate is assigned a room to himself. Patients are at liberty to wander over a large area at their end of the island.
2. No information; not many.
3. Number of admissions and discharges. Admissions to the two lazarets, 87. Discharges, 2 (one nerve case, supposed to be stationary; but the patient was re-admitted a few months later: and one considered, after observation, not to have leprosy). Remaining, at Friday Island, 27: at Stradbroke Island, 14.

I.

Western Australia during the ten years 1894—1903.

Board of Health (Dr. Ernest Black).

Previous duration of illness.	Assigned place of residence.	Date of segregation.	Repatriated.	Discharged.	Died.	Remaining.
—	Guildford, a suburb of Perth.	1902	—	—	—	Yes.

before for segregation of lepers. namely to a two-roomed cottage erected on the reserve for Maritime Quarantine at Woodman's Point, about six miles from Fremantle, but outside the part of it commonly used for quarantine purposes. In 1903 his case was reported on by a board of three physicians: they confirmed the diagnosis, and recommendet that he be continued in confinement. They also remarked that as there had been no known case of leprosy in the State for several years it was a mystery how, when, and where he became infected.

Table

Showing all cases recorded in the Northern Territory of the

Returned by the Government Medical Officer,

Consecutive No. See „A History, etc."	Name. (1)	Sex.	Age. (2)	Race or Nationality.	Occupation.	Form.
1895 20	—	M	—	Chinese	—	—
21	—	M	—	Chinese	—	—
22	—	M	—	Chinese	—	—
1896 23	—	M	—	Aboriginal	—	—
1897 24	—	M	—	Chinese	—	—
1898 25	—	M	—	Chinese	—	M
26	—	M	—	Chinese	—	M
27	—	M	—	Aboriginal	—	T
28	—	M	—	Chinese	—	N
29	—	M	—	Chinese	—	—
1899 30	—	F	—	Aboriginal	—	N
31	—	M	—	Chinese	—	M
1901 32	—	M	—	Chinese	—	N
33	—	M	—	Aboriginal	—	N
1902 34	—	M	—	Chinese	—	M
35	—	M	—	Chinese	—	M
1903 36	—	F	—	Aboriginal	—	N

1) In the case of the Northern Territory it is possible there have been a few more cases in coloured aliens and sure that there have been a good many more in aboriginals, besides the total nineteen previously enumerated, of whom there was a sufficiently certain record, and those now additionally recorded.

2) „All were adults, cases 27 and 31 being in advanced middle age". F. G.

3) „The Aboriginals all came from the Alligator River District; the Chinese from a belt of country along the railway line from 100 to 150 miles from Palmerston, except No. 16 who lived in Palmerston." F. G.

Table

Showing all cases recorded in the State of

Returned by the Chairman of the Board of

Consecutive No. See „A History, etc. (1)	Name.	Sex.	Age.	Race or Nationality.	Occupation. (2)	Form.
1897	Ah Ping.	M	22	Chinese.	—	T
	Wong Goon.	M		Chinese.	—	T
1902	Ah Fong.	M	36	Chinese.	—	M
	Paul Kong Show.	M	35	Chinese.	—	M

1) In the case of this State it is certain there had been many more cases among Chinese than the considerable number of whom some trustworthy account was given in the work referred to; but they could not be enumerated, so that the consecutive number cannot be stated.

2) Nearly all the Chinese in Australia are of the coolie class: there are a few

II.

State of South Australia during the ten yars 1894—1903.

Palmerston, N. T. (Dr. F. Goldsmith).

Previous duration of illness.	Assigned place of residence. (3)	Date of segregation.	Repatriated.	Discharged.	Died.	Remaining.
—	—	11. 6. 95.	—	—	Yes.	—
—	—	13. 1. 96.	5. 2. 96.	—	—	—
—	—	13. 4. 96.	11. 2. 97.	—	—	—
—	Alligator River.	2. 7. 96. (4)	—	Yes. (5)	—	—
—	—	23. 4. 97.	21. 5. 97.	—	—	—
—	Pine Creek.	9. 3. 99.	21. 5. 97.	—	—	—
—	—	9. 3. 99.	21. 5. 97.	—	—	—
—	Alligator River.	1. 5. 99. (4)	—	Yes. (5)	—	—
Early stage.	—	18. 8. 99.	18. 10. 99.	—	—	—
—	—	9. 11. 99.	—	—	Yes.	—
—	Alligator River.	1. 3. 00. (3)	—	Yes. (5)	—	—
Advanced stage.	—	3. 00. (6)	—	—	—	—
Early stage.	—	27. 11. 01.	Yes.	—	—	—
—	Alligator River.	2. 12. 01. (3)	—	Yes. (5)	—	—
Early stage.	—	17. 1. 02.	—	—	17. 1. 02. (7)	—
Advanced stage.	Palmerston.	14. 3. 02.	—	—	Yes. (8)	—
—	Alligator River.	1. 03.	—	Yes. (5)	—	—

4) Date of observation; not segregated.
5) „It is customary to send the Aborigines back to their country.“ F. G.
6) „Disappeared from Lazaret; supposed suicide.“ F. G.
3) Date of observation; not segregated.
7) „Committed suicide by drowning while on the voyage to the lazaret.“ F. G.
8) „Committed suicide by hanging at the lazaret.“ F. G.

III.

Victoria during the ten years 1894—1903.

Public Health (Dr. D. Astley Gresswell).

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
Late stage.	Melbourne.	16. 6. 97.	7. 97.	—	—	—
Advanced.	Mac Arthur, V.	14. 1. 97.	—	—	6. 7. 97.	—
Several years. (3)	Melbourne.	20. 11. 02.	—	—	28. 6. 03.	—
Early stage.	Melbourne.	8. 03.	—	—	—	Yes.

merchants but the remainder are employed as gardeners, hawkers, labourers, gold-miners, cooks, etc. etc. and, except in the latter capacity, very rarely as house-servants.

3) Probably infected before arrival in this State. D. A. G.

Table

Showing all the cases which have been recorded in the

Case No. in Annual Reports.	Consecutive No. See „A History etc."	Name.	Sex.	Age.	Race or Nationality.	Occupation.	Form.
1894							
XLII	71	C. H. M.	M	66	German, Saxony.	Sailor. Station hand.	T
XLIII	72	W. H. D.	M	20	Australian, Q. (1)	Student.	T
XLIV	73	G. N.	M	20	New Caledonia.	Pearl Diver.	T
XLV	74	H. J. T.	M	52	Australian. NSW.	Labourer.	N
XLVI	75	K. J.	M	30	E. Indian.	Hawker.	N
1895							
XLVII	76	A. K.	F	38	Australian. NSW.	House.	T
XLVIII	77	J. T.	M	70	English.	Labourer.	N
XLIX	78	J. B.	M	49	Australian, NSW.	Miner & farmer.	N
L	79	X. Y.	F	51	Australian, NSW.	House.	N
LI	80	X. Z.	F	35	Australian, NSW.	House.	N
LII	81	W. F.	M	40	Irish.	Clerk.	T
LIII	82	T. O. R.	M	70	Irish.	Labourer.	T
1896							
LIV	83	Hing Yung.	M	26	Chinese.	Gardener.	N
LV	84	Hung Jeung.	M	31	Chinese.	Hawker.	T
LVI	85	Ah Tai.	M	31	Chinese.	Gardener.	N
1897							
LVII	86	X. X.	M	60	Australian, Q.	Independent.	N
LVIII	87	F. R.	M	54	Belgian.	Mechanic.	T
LIX	88	H. W.	M	57	American.	Sailor, farmer.	N
1898							
LX	89	Ah Yen	M	35	Chinese.	Gardener.	N
LXI	90	W. W.	M	19	Australian, NSW.	Labourer.	T
LXII	91	R. C.	M	27	Australian, NSW.	Butcher.	T
LXIII	92	P. H.	M	29	Australian, NSW.	Labourer.	T

1) Such an entry as „Australian, Q" in the column headed „Race or Nationality" signifies a native, the child of white parents born in that State which is indicated by the terminal initial. The autochthons are commonly called „aboriginals".

2) A plus sign following the stated, „previous duration of illness" means that the illness had lasted indeterminably longer, but not less than the term fixed. This patient's disease became stationary, and he was discharged to his home.

3) Was not segregated; had already concealed herself prior to actual notification.

4) Was observed while an ordinary patient at the Coast Hospital: took himself off before the second certificate required by law had been obtained, and was not traced.

5) There was never question of segregating this patient, whose disease had long been quiescent: she died as shown, but of disease of the kidneys.

IV.

State of New South Wales during the 10 years 1894—1903.

Previous duration of illness.	Assigned place of residence.	Date of segregation.	Repatriated.	Discharged.	Died.	Remaining.
5 years.	N. S. W. & Q.	25. 1. 94.	—	—	8. 7. 98.	—
12 years.	Brisbane, Q.	18. 4. 94.	—	—	29. 11. 96.	—
Early stage.	Thursday Isld. Q.	16. 7. 94.	—	—	2. 9. 95.	—
9 years †. (2)	Macleay River NSW 31° 9′ S. Lat 152° 50′ E. Long.	10. 10. 94.	—	5. 9. 02.	—	—
6 years †.	12 years in Australia travelling.	30. 11. 94.	—	—	2. 8. 95.	—
6 years †.	Hunter River District, NSW.	1. 95. (3)	Escaped same time	Escaped same time	—	—
2 years †.	Sydney.	4. 4. 95.	—	—	6. 11. 97.	—
2 years.	Goulburn, NSW.	4. 95. (4)	—	—	—	—
39 years.	Sydney.	5. 95. (5)	—	—	1903.	—
17 years.	Sydney.	5. 95. (6)	—	—	—	—
4 years.	Sydney.	8. 10. 95.	—	—	8. 11. 96.	—
Not known. (7)	Sydney.	2. 10. 95.	—	—	8. 11. 95.	—
Doubtful.	Sydney.	4. 2. 96.	14. 8. 96.	—	—	—
5 years.	Newcastle, NSW.	21. 2. 96.	14. 8. 96.	—	—	—
11 years †. (8)	Riverina District.	22. 12. 96.	17. 7. 97.	—	—	—
Not ascertain. (9)	Queensland.	2. 97.	—	—	—	—
Advanced stage.	New Caledonia.	16. 2. 97.	—	—	23. 6. 97.	—
5 years.	Lord Howe Island NSW.	12. 11. 97.	—	—	—	Yes.
Doubtful.	Botany, Sydney.	18. 1. 98. (10)	—	—	30. 1. 98.	—
10 years.	Wollongong, NSW.	26. 2. 98.	—	—	21. 2. 00.	—
1 years.	Wollongong, NSW.	5. 7. 98.	—	—	30. 4. 03.	—
— (11)	Wollongong, NSW.	—	—	—	7. 84.	—

6) See note 5: a similar remark applies. Both cases have merely historical importance.

7) Admitted as an ordinary patient at the Coast Hospital, and died of pleurisy: leprosy was diagnosed immediately before death.

8) Probably began to suffer before leaving China.

9) Not segregated; the patient had visited Sydney for medical advice, and was placed on board a steamer for Brisbane as soon as his case had been notified: he lived in Queensland, where he had a good deal of property.

10) Not segregated; was admitted as an ordinary patient to Sydney Hospital, where he died of some other disease. Leprosy was diagnosed shortly before his death, and the bacillus was afterwards demonstrated in nerve trunks.

11) This patient had died fourteen years before his case was heard of in the course of inquiry into the history of the two preceding cases.

Case No. in Annual Reposts	Consecutive No. See "A" History etc.	Name	Sex	Age	Race or Nationality	Occupation	Form
1898							
LXIV	93	A. B.	M	20	Australian, NSW.	Labourer	T
LXV	94	A. Quong.	M	30	Chinese.	Gardener.	T
LXVI	95	Ah Gu.	F	44	Chinese.	House.	T
1899							
LXVII	96	J. F. D.	M	26	Australian, NSW.	Labourer.	T
1900							
LXVIII	97	Chow Ping.	M	23	Chinese.	Cook.	T
1901							
LXIX	98	Billy Aoba	M	35	New Hebrides.	Labourer.	N
LXX	99	C. T.	F	29	German. (13)	House.	T
LXXI	100	D. N.	M	18	Australian, NSW.	Labourer.	T
LXXII	101	J. S.	M	53	Australian, NSW.	Farmer.	N
LXXIII	102	D. L.	M	42	English.	Labourer.	T
LXXIV	103	F. H.	M	75	English.	Sailor, Stoker.	T
LXXV	104	Ah Rum	M	25	Chinese.	Labourer.	N
LXXVI	105	Ah Taw	M	35	Chinese.	Labourer.	T
1902							
LXXVII	106	Gin Yung	M	Aged	Chinese.	?	N
1903							
LXXVIII	107	J. G.	M	57	Australian, NSW.	Grazier.	T
LXXIX	108	M. J. S.	M	45	Irish.	Miner.	T
LXXX	109	Hook Ling	M	32	Chinese.	Gardener.	T
LXXXI	110	G. S. N.	M	52	English.	Farmer.	T
LXXXII	111	F. C.	M	17	Fiji (White).	School.	T
LXXXIII	112	Ah Shang	M	51	Chinese.	Wood-cutter.	T
LXXXIV	113	S. V.	M	22	E. African Mombassa.	Cook.	T
LXXXV	114	Tommy Bow	M	37	Chinese.	Cook.	N
LXXXVI	115	Billy Munroe	M	36	New Hebrides.	Labourer.	T
LXXXVII	116	F. E. B.	M	27	Australian, NSW.	Drover.	N

12. Not segregated; the patient was observed in the general wards of the Coast Hospital, and was discharged to a ship for China.
13. Born emigrated to Australia at one year of age.

Table

Showing all cases recorded in the State of

The first case completes the account for the

[illegible]	Name	Sex.	Age	Race or Nationality	Occupation	Form
1894 [illegible]	F. M.	M	23	Australian, Q.	Labourer	N

1 There have without doubt been very many more cases in aliens, and probably [illegible] in this State, than the 47 Which alone could be enumerated on [illegible] good evidence in the earlier account.

The following notes concerning cases in whites which appear in table have been abstracted from notes furnished by the Commissioner of Public Health Dr. B. B[illegible] Ham:

2 Born and lived in Brisbane till 10 years old, then to Rockhampton; has

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
3 years.	Gunnedah, NSW.	21. 3. 98.	—	—	7. 7. 01.	—
Doubtful.	Botany, Sydney.	15. 9. 98. (12)	1. 10. 98.	—	—	—
11 years †.	Waterloo, do.	20. 9. 98.	—	—	4. 2. 01.	—
4 months.	Lismore, NSW.	11. 7. 99.	—	—	—	Yes.
Middle stage.	Sydney.	14. 4. 00.	—	—	16. 5. 03.	—
Doubtful.	TweedRiver,NSW.	26. 2. 01.	1. 12. 02.	—	—	—
3 years.	Lismore, NSW.	23. 4. 01.	—	—	14. 12. 03.	—
4 years.	Glen Innes, NSW.	4. 6. 01.	—	—	—	Yes.
5 years.	Barraba, NSW.	20. 6. 01.	—	28. 2. 02. (14)	—	—
Advanced stage.	Wanderer, and Criminal.	20. 6. 01.	—	—	15. 12. 02.	—
Middle stage.	Sydney.	4. 7. 01.	—	—	—	Yes.
Doubtful.	Sydney.	30. 10. 01.	—	—	—	Yes.
Middle stage.	Sydney.	4. 12. 01.	—	—	—	Yes.
?	?	8. 1. 02. (15)	—	—	17. 1. 02.	—
5 years.	Singleton.	13. 1. 03.	—	—	—	Yes.
3 years.	Parramatta, NSW.	20. 2. 03.	—	—	—	Yes.
Middle stage.	Sydney.	10. 3. 03.	—	—	—	Yes.
3 years.	TweedRiver,NSW.	7. 4. 03.	—	—	—	Yes.
3 years.	Rewa River, Fiji.	7. 4. 03.	—	—	—	Yes.
Middle stage.	Canterbury,Sydn.	21. 4. 03.	—	—	—	Yes.
Early stage.	Sydney.	5. 6. 03.	—	—	—	Yes.
Doubtful.	Sydney.	30. 6. 03.	—	—	—	Yes.
3 years.	TweedRiver,NSW.	3. 11. 03.	—	—	—	Yes.
5 years.	TweedRiver,NSW.	25. 11. 03.	—	—	—	Yes.

14) This patient (who was admitted and released during my absence from the State) was discharged to his home on the ground that his disease was stationary.

15) Very aged; spoke little English.

V.

Queensland during the 10 years 1894—1903.

year 1894 partly given in „A History“.

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
3 years	Rockhampton	19. 12. 94	—	—	16. 4. 02	—

visited both Mackay and Maryborough for short terms. Has had a patch of discolouration on front of left thigh for 3 years, and suffered from „growing pains“ during same term. On admission showed thickening of the ulnar and peroneal nerves, anaesthesia of hands and feet, and the large macule referred to; during detention had periodical attacks of fever accompanied by swelling of both elbow-joints, which lasted about ten days at a time, and were followed by appearance of small erythematous patches on chest and abdomen.

Consecutive No. See „A History etc.		Name	Sex	Age	Race or Nationality	Occupation	Form
1895	49 (3)	J. C. W.	M	11	Australian, Q.	School	T
	50	—	M	36	Kanaka	—	T
	51 (4)	J. B.	M	59	English	Sailor, then miner	M
	52	—	M	40	Solomon Islands	—	T
	53	—	M	40	Kanaka	—	T
	54 (5)	J. J. I.	M	45	Australian, NSW.	—	T
	55	J. L. W.	M	43	English	Miner	N
	56	—	M	40	Kanaka	—	M
1896	57	—	M	?	Kanaka	—	—
	58	—	M	22	Aboriginal	—	T
	59	—	M	32	Kanaka	—	T
	60	—	M	35	Solomon Islands	—	T
	61	—	M	24	Murray Islands New Caledonia	—	T
	62	—	M	Adult	Chinese	—	—
	63	—	M	do.	Chinese	—	—
	64 (6)	M. B.	M	57	Irish	Various	N
	65	—	M	Adult	Chinese	—	—
	66 (7)	I. C.	F	28	Australian, Q.	Servant	T
	67 (8)	A. W.	M	52	English	Carpenter	T
	68	—	M	30	Aboriginal	Stockman	T
	69	—	M	36	Kanaka	—	T
	70	—	M	35	Malayta Island	—	T
	71	—	M	Adult	Chinese	—	—

3) Born of the voyage from England to Queensland, has lived ever since at Brisbane. Parents English; is the third of a family of 4, all in good health. First signs date 6 months before admission; they were discolouration and swelling of the face; previous to this had always enjoyed good health; no history of contact of any sort with lepers. From a photograph taken 8 months ago it is possible to judge that the history given of appearance of first external signs was probably correct. A tuberous case, furnishing the usual signs. Bacillus demonstrated. Filaria were also found in his blood.

4) Born England; arrived Melbourne, Victoria, 1869; has lived ever since in Victoria, New South Wales, and Queensland. Before reaching Australia (at age 27) had been a sailor for 4 years, and had visited the Mediterranean ports, Syria, and North Africa. No known contact with lepers. In Queensland had lived on various Northern gold-fields. A tuberous case; usual signs are described.

5) Born at Richmond, N. S. W., Alleges family in good health. Dates illness from 1882 when a red rash appeared on his face, and gradually spread over the upper part of the body; after this he noticed that the skin of the forehead and ears became thickened, and hair of eyebrows and eyelashes dropped out. A tuberous case: usual signs described, but it is noted that there was no thickening of the ulnar or any superficial nerve.

6) Born Ireland; arrived Sydney 1841; went to Brisbane in 1863, and has lived there ever since. Has grown-up sons and daughters, in good health. A nerve case. Forty years ago had a bad attack of primary syphilis, no history of secondary illness. The principal signs of his disease have shown themselves in the feet and ankles of both legs. Duration at least 5 years; the described signs were merely some small ulcers, one being „at the base of the ball of the great toe, right foot". There was also partial loss of sensation in the dorsum of both feet. On 20. 12. 97 the Central

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
6 months	Brisbane	14. 3. 95	—	—	7. 5. 98	—
?	Brisbane	26. 3. 95	—	—	31. 1. 96	—
8 years	Charters Towers	10. 4. 95	—	—	7. 10. 99	—
several years	Beenleigh	2. 5. 95	—	—	25. 8. 99	—
15 months	Mackay	17. 6. 95	—	—	27. 11. 99	—
13 years	Brisbane	10. 8. 95	—	—	8. 11. 97	—
several years	Herberton	31. 8. 95	—	—	9. 10. 01	—
—	Rockhhampton	18. 12. 95	—	—	?	—
—	Rockhampton	21. 2. 96	—	—	19. 9. 96	—
—	Geraldton, but a native of Port Darwin	28. 2. 96	—	—	—	—
7 years	Geraldton	29. 2. 96	—	—	1. 7. 02	—
6 months	Herberton	10. 3. 96	—	—	3. 6. 99	—
—	Cardwell	19. 3. 96	—	—	1. 12. 98	—
—	Toowoomba	7. 4. 96	—	—	—	—
—	Warwick	4. 5. 96	—	—	—	—
4 years †	Brisbane	1. 5. 96 18. 5. 98	—	28. 12. 97	7. 10. 02	—
—	Cairns	15. 5. 96	—	—	—	—
1 year †	Brisbane	8. 8. 96	—	—	4. 2. 99	—
—	Coomera	5. 10. 96	—	—	5. 1. 99	—
1 year	Croydon	21. 10. 96	—	—	—	—
Late stage	Bundaberg	27. 10. 96	—	—	12. 96 Suicide	—
2 years	Cairns	27. 10. 96	—	—	9. 99 Suic.	—
—	Ingham	28. 11. 96	—	—	—	—

Board of Health discharged him „all ulcers having been healed 3 months“, on condition that he kept himself apart from others and reported himself for survey to a Government Medical Officer once a month. On 4. 5. 98 the Government Medical Officer reported that „his disease had broken out afresh“ and he was again sent to the lazaret, where he soon died. No details of importance seem to have been placed on record.

7) Was born 1872 at South Brisbane; family all healthy. Says she has always had an antipathy to coloured people. In 1888 went out to service in Brisbane; in 1893 went into the country to Taroom in service; there were there two black boys, who had their meals in the kitchen with her, but with whom she did not otherwise associate. Says she had no illness while there: returned to Brisbane 1894. Her mother noticed her altered appearance; flattened nose, loss of eyebrows and eyelashes. She took service as cook in Brisbane, but could continue only two days as she felt too weak to work; applied at a hospital, and was reported thence as a suspect. She showed very marked signs of tuberous leprosy of the usual kind, and it was noted that the mucous membrane of nostrils and fauces was dotted with nodules which frequently broke down; at admission also, her voice was raucous. The bacillus was demonstrated.

8) Born England; arrived Sydney at 4 years old, reached Queensland at 25, settled in the Coomera district near Brisbane, and lived there for 20 years; at 40 met with an accident and lost the sight of one eye; at 44 lost the sight of the other eye: 2 years before admission had been an inmate of an institution for the blind. Has 7 children alive and in good health. Has never had any other serious illness. A tuberous case showing the usual signs; during the latter part of his illness had repeated attacks of swelling of the testes which lasted for 2 or 3 days at a time, and then disappeared. There is no account of onset.

	Consecutive No. See „At History etc.	Name	Sex.	Age	Race or Nationality	Occupation	Form
1896	72 (9)	F. R.	M	41	Irish	Sailor, then farmer	T
	73 (10)	T. B.	M	67	English	Miner	T(b)
	74	—	M	—	Kanaka	—	T
	75	—	M	Adult	Chinese	—	N
	76	—	M	do.	Chinese	—	—
	77	—	M	—	Kanaka	—	T
	78	—	M	29	Kanaka (Lagon)	—	N
1897	79 (11)	J. S.	M	51	Maori	—	N
	80	—	M	Adult	Aboriginal	—	—
	81 (12)	W. A. G.	M	46	English	—	T
1898	82	—	M	30	Kanaka	—	T
	83	—	—	--	Chinese	—	N
	84 (13)	J. A. C.	M	38	English	Sailor, Soldier, Labourer	T
	85 (14)	W. P.	M	42	English	—	T
	86	P. R. S.	M	19	Australian, Q.	School	T
	87	—	F	—	Aborig., halfcaste	—	—
	88	—	M	—	Kanaka	—	T
1899	89	—	M	Adult	Aboriginal	—	—
	90	—	M	—	Kanaka	—	—
	91	—	F	—	Kanaka	—	T
	92	—	M	—	Kanaka	—	—
	93	—	M	27	Kanaka	—	—
	94	—	M	—	Kanaka	—	—
	95	—	M	—	Kanaka	—	—
	96	—	M	—	Chinese	—	T
	97	—	M	—	Kanaka	—	T
	98 (15)	R. J. J.	M	—	English	Miner, book-keeper	T

9) Was born in Ireland at Belfast, at 15 years of age went to sea; visited Rangoon and America; came to Queensland about 21 years ago. Has followed various occupations, chiefly farming. Has had two bad attacks of syphilis in the course of his life. Five months ago was for two months an in-patient at Brisbane Hospital for abscess of the arm; he returned after discharge suffering from what he thought were rheumatic pains, and his disease was then recognised. A tuberous case which is described as having presented the usual signs in very marked degree.

10) Born England; arrived in New South Wales 1838; removed to Queensland 1848. For many years he had charge of pastoral stations in many parts of the State, and more recently engaged in mining on the northern goldfields and at Thursday Island. No serious disease in his family; has had several attacks of malarial fever. A tuberous case which offered the usual signs. The bacillus was demonstrated.

11) A half-caste Maori. His father was born in Ireland, his mother was an aboriginal of the North Island, New Zealand. Was born at Castlereagh, N. S. W.: says his parents, who are dead, where both healthy people; had 13 brothers and sisters who were all in good health some years ago. At age 21 arrived in Queensland, where he has been ever since; has lived at Aramac, Blackall, and other Northern districts. He had always enjoyed good general health, and on admission was in good general condition. A tuberous case, which showed deep infiltrations in the usual localities, on which it was noted, bullae from time to time had appeared.

12) Was born at Oxford, England, and arrived at Cooktown in 1874. „This

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
—	Blackall	17. 11. 96	—	—	27. 8. 99	—
—	Northern Goldfields	28. 2. 97	—	—	25. 11. 98	—
—	Brisbane	18. 3. 97	—	—	—	—
—	Rockhampton	23. 3. 97	—	—	—	—
—	Toowoomba	4. 5. 97	—	—	—	—
—	Ayr	31. 5. 97	—	—	—	—
2 years	Geraldton	2. 6. 97	—	—	1. 5. 00	—
—	Clermont	18. 6. 97	—	—	—	Yes
—	Cooktown	29. 7. 97	—	—	3. 7. 98	—
3 years †	Townsville	26. 12. 97	—	—	26. 3. 00	—
—	Cairns	5. 1. 98	—	—	15. 12. 00	—
—	Cairns	12. 3. 98	Escaped in transit	Escaped in transit	Escaped in transit	—
—	Brisbane	4. 8. 98	—	—	—	Yes
8 years	Nambour	17. 8. 98	—	—	29. 3. 03	—
1 year	Brisbane	22. 9. 98	—	—	—	Yes
—	Charleville	7. 10. 98	—	—	1. 2. 03	—
—	Childers	10. 11. 98	—	—	16. 3. 99	—
—	Starkey River	30. 1. 99	—	—	12. 4. 99	—
—	Ayr	—	—	—	11. 12. 99	—
—	Mackay	22. 2. 99	—	—	—	—
—	Mackay	28. 3. 99	—	—	18. 11. 02	—
—	—	28. 3. 99	—	—	30. 12. 03	—
—	—	28. 3. 99	—	—	—	—
—	Thursday Island	28. 3. 99	—	—	18. 7. 00	—
—	Geraldton	25. 4. 99	—	—	—	—
—	Ingham	29. 4. 99	—	—	—	—
9 years	Ingham	8. 5. 99	—	—	15. 6. 00	—

patient suffered from a sudden and severe attack, the first observed, of swellings of the eyebrows, brows, and greater prominences. No ulcer formed, but the eyes were greatly congested. These symptoms continued for three weeks, but have now disappeared and fair health is enjoyed."

13) Born at Quinton, Buckinghamshire, England; arrived at age 14: went to sea, principally in coasting boats: returned to England at age 28, enlisted and served 2 years; served other 2 years in India; was invalided, and discharged as incurable from heart disease following on acute rheumatism; returned to Queensland; worked at sugar mill, and again at sea. He noticed patches on his body after his return from India. A tuberous case; the bacillus was demonstrated.

14) English by birth; arrived Queensland at age 20; parents and 6 brothers, 1 sister, living in Queensland and healthy. Lived for 3 years at Hemmant, for a time at Buderim Mountain, and settled at Nambour at age 25, where he has lived ever since. First noticed the disease about 8 years ago; says the lumps on his face were much bigger two years ago than now. The bacillus was demonstrated.

15) Born and brought up in London; arrived in New Zealand in 1865, removed to Victoria in 1868, reached Queensland in 1873 where he has remained ever since. The first part of his life in Queensland was spent on various goldfields; for about 9 years previous to admission had worked as book-keeper on various plantations at Ingham; he was there brought much into contact with kanakas, Chinese, and Malays, but never associated with them. Disease began about 9 years ago. A tuberous case; the bacillus was demonstrated.

Consecutive No. See A History etc.	Name	Sex.	Age	Race or Nationality	Occupation	Form
1899 99	—	M	—	Kanaka	—	—
100 (16)	J. H.	M	57	Danish	—	—
101	—	—	—	Kanaka	—	T
102	—	F	—	Kanaka	—	T
103	—	M	—	Kanaka	—	T
1900 104	—	M	—	Kanaka	—	T
105	—	M	—	Kanaka	—	T
106	—	M	—	Kanaka	—	T
107	—	M	—	Kanaka	—	—
108	—	F	—	Aboriginal	—	T
109	—	M	—	Kanaka	—	T
110	—	M	—	Aboriginal	—	—
111 (17)	G. S.	M	37	Australian, Q.	Station hand	N
1901 112	B. H.	F	40	White	House wife	T
113 (18)	S. B.	M	12	Australian, Q.	School	T
114	—	M	—	Kanaka	—	T
115	—	M	—	Kanaka	—	T
116	—	M	—	Kanaka	—	T
1902 117 (19)	W. G. A. G.	M	60	English	Civil Servant	T
118	—	M	Adult	Aboriginal	—	N
119 (20)	O. B.	F	9	Australian, Q.	School	T
120	—	M	—	Kanaka	—	T
121	—	M	—	Kanaka	—	T
122	—	M	—	Kanaka	—	N
123	—	M	—	Kanaka	—	T
124	—	M	—	Kanaka	—	T
125	—	M	—	Kanaka	—	T
126	—	M	—	Kanaka	—	—
127	—	M	—	Kanaka	—	—
1903 128	—	M	40	Aboriginal	—	—
129	—	M	—	Kanaka	—	—
130	—	M	—	Kanaka	—	T
131	—	M	—	Kanaka	—	T
132	—	M	—	Aboriginal	—	—

16) Born and brought up in Denmark; as a sailor arrived in Queensland in 1868, where he has remained ever since. His residence in Queensland has been chiefly on pastoral stations in the far west, where he lived with aboriginals; has been an opium smoker. Says he never had any illness until three years ago when he began to suffer from asthma, as he still does. On admission it was noted that the only indication of leprosy consisted in a patch of discoloured skin on the left side which extended from below the ribs to the lower part of the hip; numbness in both the left hand and foot had quite recently been observed: and about four months previously an erythematous rash had appeared while he was an in-patient at Isisford hospital, where he was under treatment for asthma. In November, 1901, the medical members of the Central Board of Health examined him, and were of opinion that he showed no signs of leprosy. Some expectoration was referred to the Government Bacteriologist who reported presence of a bacillus which gave the re-actions common both to b. leprae and b. tuberculosis: cultivation and inoculation experiments were therefore instituted. An addendum to the Bacteriologist's report made by the Commissioner of Public Health stated that the results of bacteriological examination

Previous duration of illness	Assigned place of residence	Date of segregation	Repatriated	Discharged	Died	Remaining
—	Ingham	26. 5. 99	—	—	27. 12. 00	—
—	Isisford	9. 6. 99	—	17. 1. 02	—	—
—	Mackay	23. 8. 99	—	—	7. 6. 01	Yes
—	Brisbane	4. 8. 99	—	—	—	—
—	Bundaberg	19. 10. 99	—	—	26. 9. 01	—
—	Townsville	4. 1. 00	—	—	—	—
—	Mackay	4. 1. 00	—	—	—	—
—	Ayr	4. 1. 00	—	—	—	—
—	Mackay	12. 1. 00	—	—	—	—
—	Mackay.	12. 1. 00	—	—	—	—
—	Port Douglas	27. 4. 00	—	—	—	—
—	Eulo	19. 7. 00	—	—	—	—
—	Charleville	30. 10. 00	—	—	—	Yes
Early stage	Townsville	21. 1. 01	—	—	—	Yes
—	Ayr	1. 8. 01	—	—	—	Yes
—	Rockhampton	19. 9. 01	—	—	21. 3. 02	—
—	Ayr	27. 9. 01	—	—	—	—
—	Ingham	4. 10. 01	—	—	—	—.
—	Brisbane	7. 3. 02	—	—	—	Yes
—	—	—	—	—	11. 4. 02	—
6 months	Townsville	27. 5. 02	—	—	—	Yes
—	Thursday Island	8. 7. 02	—	—	—	—
—	Townsville	23. 8. 02	—	—	17. 12. 02	—
—	Townsville	13. 9. 02	—	—	—	—
—	Ingham	3. 10. 02	—	—	5. 2. 04	—
—	Townsville	3. 10. 02	—	—	—	—
—	Ingham	3. 10. 02	—	—	—	—
—	Townsville	16. 12. 02	—	—	—	—
—	Townsville	13. 12. 02	—	—	—	—
—	Banana, Rockhampton	22. 10. 03	—	—	—	—
—	Townsville	10. 10. 03	—	—	—	—
—	Ayr	10. 10. 03	—	—	—	—
—	Mackay	10. 10. 03	—	—	—	—
—	—	22. 10. 03	—	—	—	Yes

were negative; a guinea-pig inoculated with the expectoration showed no evidence of tuberculosis after 45 days. The patient was released as shown above.

17) A native of Queensland. Was a station-hand in the west between Charleville and Cunnamulla. Had worked on a station whence an aboriginal woman had been removed suffering from leprosy. No further history. A tuberous case which was progressing rather rapidly.

18) A native of Queensland who lived with his family at Ayr. No further history. A tuberous case, in which the bacillus was demonstrated. Tubercles on face and ribs; hands and feet swollen, occasional sores here; the disease progressed rather rapidly, and in 1903 it was noted that he had an eruption of tubercles, like small pimples, on the soles of the feet.

19) Had been an inmate of Dunwich Benevolent Asylum. Was notified from Brisbane Hospital. No further history. A tuberous case which showed the usual signs.

20) A girl of European parentage; lived at Townsville. First appearance of eruption dated five months before admission. A tuberous case; the bacillus was demonstrated.

Consecutive No. See A History etc.	Name	Sex.	Age	Race or Nationality	Occupation	Form
1903 133 (21)	R. W.	M	69	English	At Blind Institution Brisbane	T
134	—	M	—	Kanaka	—	T
135	—	M	32	Kanaka	—	T
136 (22)	J. J. F.	M	30	Australian, Q.	Farmer	T

21) Was an inmate of the Blind Asylum for 16 years prior to admission, and worked in the same room as Case 67 (See note No. 8). No further history. On admission, sores under each foot; body covered with an eruption of a reddish brick colour, circular in form; this eruption also extended to the forehead and behind the ears; right ear and both hands swollen; slight hypertrophy of both eyebrows; sores and blisters which were present on his fingers have healed up rapidly since admission; other symptoms unchanged. Previous duration of illness, two years.

1904.

REPORT

on

Leprosy in New South Wales.

For the Year 1902.

The Chief Medical Officer of the Government and President of the Board of Health to The Honourable the Premier and Chief Secretary.

Department of Public Health,
Sydney, 31ste March, 1904.

Sir,

On 1st January, 1902, fourteen persons remained under detention at the lazaret. (See Appendix A.)

During the year two persons were reported to the Board under the Leprosy Act, 1890, as being suspected lepers. One of these died on the day of report, and was buried before any diagnosis could be made: the other, after careful inquiry, was deemed to be not suffering from leprosy. A third, whose case had been reported at end of the previous year, was admitted.

Two patients died during the year; one was a native of England, and one a Chinese. Three patients were discharged: Billy Aoba (see Report 1901, Appendix C, case LXIX), lepra nervorum, was returned to his island: J. S. (ibidem, case LXXII) and H. J. T. (see Report 1894, Appendix C, case XLV), both cases of lepra nervorum, and natives (whites) of this State, were discharged to their homes on the ground that in the first-mentioned the disease was quiescent, and in the second that, after a long period of observation, it had been seen to become, and to remain, quiescent. In this latter case the charitable allowance which had been made to the patient's family during the [illegible]

Previous duration of illness	Assigned place of residence	Date of segre-gation	Re-patriated	Dis-charged	Died	Remaining
2 years	Brisbane	21. 11. 03	—	—	—	Yes
—	Geraldton	18. 12. 03	—	—	—	—
—	Mackay	18. 12. 03	—	—	—	—
2 years	Childers	23. 12. 03	—	—	—	Yes

22) A native of Queensland, a farmer: has lived 21 years at Maryborough, and the last four years at Nanango and Isisford district. First signs occured two years before admission, when his ears began to grow large and thick. A tuberous case which exhibited the usual signs; his ears were inmensely thickened and elongated.

of his segregation was continued, it being very unlikely that his trophic mutilations would allow of his earning a livelihood, supposing he should be successful in obtaining any employment.

Thus the number remaining in the lazaret on 31st December, 1902, was 10 persons; 6 were whites, 3 of whom were natives of New South Wales of European descent, 1 was a native of Germany (female), 1 was a native of England, and 1 a native of the United States of America. Of the coloured lepers, 1 was a Javanese, and 3 were natives of China.

In Appendix B appears a complete statement of the sex, birthplace, occupation, age at and date of admission, former residence, and date of decease or discharge of all persons admitted to the lazaret from the beginning. The Roman numerals have reference to further details given in Appendix C hereto, and in Appendices to the Reports for former years.

From the Summary of Appendix A it will be seen that the total number of persons admitted since 1883, when patients first began to be received (though the notification of leprosy was first made compulsory, and the detention of lepers provided for by law only towards the end of 1890), is 78. Distributed under nationalities, the account stands as follows: — Natives of New South Wales, 21, of whom 15 have died and 2 were released; of Queensland, 1, deceased; of England, 4, of whom 3 have died; of Ireland, 2, deceased; of New Zealand, 1, deceased; of Fiji, 1, deceased; of Germany, 2, of whom 1 has died; of Belgium, 1, deceased; of the United States of America, 1; and all of these were whites, of European descent. There were also 37 natives of China, of whom 13 have died, and 21 have been returned to their own country; of India, 2 deceased; of the West Indies, 1, discharged in 1885; of Java, 1; of Tanna (New Hebrides), 1, deceased; of New Caledonia, 1, deceased; of Aoba (New Hebrides), 1, returned to his island; and all of these were coloured people.

Every opportunity has been given to members oft the medical

profession to visit the lazaret for the purpose of seeing such patients as were formerly under their care, and for study of the disease.

The following statements show the Expenditure for the year 1902, and the sources from which it has been defrayed:—

Statement showing the Working Expenses of the Lazaret (for men and for women) at Little Bay for the year 1902:—

	£	s.	d.
Salaries	506	1	3
Provisions	548	19	2
Fuel	89	6	0
Drugs, disinfectants, &c	85	0	0
Fruit	13	18	3
Tobacco	33	5	10
Drapery, bedding, uniforms, &c	81	14	8
Furniture, ironmongery, glass, and brushware	43	14	2
Stationery	0	12	3
Repairs	124	7	11
Wine, beer, spirits	51	1	9
Newspapers, periodicals	21	3	11
Medical examination of lepers	15	15	0
Sundries	81	14	8
Total	£1,696	14	10

Average annual number of patients in residence, 12·72, being equal to an average of £ 133 7 s. 9 d. per inmate per annum.

Statement of the total Expenditure of the Lazaret (for men and for women) at Little Bay during the year 1902, showing from what sources the amounts have been paid:—

Expenditure.	£ s. d.	How Paid.	£ s. d.
To working expenses, as per attached statement	1,696 14 10	From vote for the maintenance of lepers by the Board of Health	1,395 0 8
		From vote of stores by the Chief Inspector of Stores	177 6 3
		From vote under control of Works Department	124 7 11
Total	£1,696 14 10	Total	£1,696 14 10

The needs of the patients have been carefully supplied by experienced attendants and nurses, under the direct supervision of the Medical Superintendent and the Matron of the Coast Hospital, and, as in the past, every means has been adopted to alleviate their sufferings and to mitigate the hardships of their detention.

I have, &c.

J. Ashburton Thompson.

APPENDIX.

(A.)

Return showing number of persons found to be suffering from Leprosy and removed to the Lazaret at Little Bay, New South Wales, since 1883; also Deaths and Discharges for each year.

	Natives of—															
	New South Wales	Queensland	New Zealand	Fiji	New Hebrides	NewCaledonia	Java	China	India	Germany	Belgium	England	Ireland	West Indies	U.S.A.	Total
1883.																
Admitted during the year	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	5
Died do.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1884.																
Remaining in on January 1	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	5
Admitted during the year	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	2
Died do.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1885.																
Remaining in on January 1	—	—	—	—	—	—	—	7	—	—	—	—	—	—	—	7
Admitted during the year	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	2
Died do.	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
Discharged do.	—	—	—	—	—	—	—	—	—	—	—	—	—	1 [1])	—	1
1886.																
Remaining in on January 1	—	—	—	—	—	—	—	7	—	—	—	—	—	—	—	7
Admitted during the year	—	—	—	—	—	—	1	2	—	—	—	—	—	—	—	3
Died do.	—	—	—	—	—	—	—	4	—	—	—	—	—	—	—	4
1887.																
Remaining in on January 1	—	—	—	—	—	—	1	5	—	—	—	—	—	—	—	6
Admitted during the year	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
Died do.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1888.																
Remaining in on January 1	—	—	—	—	—	—	1	6	—	—	—	—	—	—	—	7
Admitted during the year	1	—	—	—	—	—	—	3	—	—	—	—	—	—	—	4
Died do.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1889.																
Remaining in on January 1	1	—	—	—	—	—	1	9	—	—	—	—	—	—	—	11
Admitted during the year	1	—	—	—	—	—	—	1	—	—	—	—	—	—	—	2
Died do.	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
1890.																
Remaining in on January 1	2	—	—	—	—	—	1	10	—	—	—	—	—	—	—	13
Admitted during the year	2	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Died do.	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	2
1891.																
Remaining in on January 1	4	—	—	—	—	—	1	8	—	—	—	—	—	—	—	13
Admitted during the year	5 [2])	—	—	—	1	—	—	4	—	—	—	—	—	—	—	10
Died do.	1	—	—	—	—	—	—	1	—	—	—	—	—	—	—	2
1892.																
Remaining in on January 1	8	—	—	—	1	—	1	11	—	—	—	—	—	—	—	21
Admitted during the year	2	—	—	1 [3])	—	—	—	8	—	—	—	1	—	—	—	12
Died do.	2	—	—	—	—	—	—	1	—	—	—	—	—	—	—	3

1) Discharged on the 29th December, 1885. his sores having healed and there being no law warranting his detention.

2) One patient, I. L., reported 18th December, 1891, was removed to Little Bay on 12th January, 1892.

3) Of European descent.

	New South Wales	Queensland	New Zealand	Fiji	New Hebrides	NewCaledonia	Java	China	India	Germany	Belgium	England	Ireland	West Indies	U.S.A.	Total
	Natives of—															
1893.																
Remaining in on January 1	8	—	—	1	1	—	1	18	—	—	—	1	—	—	—	30
Admitted during the year	3	—	1[1])	—	—	—	—	2	1	—	—	—	—	—	—	7
Died do.	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
1894.																
Remaining in on January 1	11	—	1	1	1	—	1	19	1	—	—	1	—	—	—	36
Admitted during the year	1	1	—	—	—	1	—	—	1	1	—	—	—	—	—	5
Died do.	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
1895.																
Remaining in on January 1	11	1	1	1	1	1	1	19	2	1	—	1	—	—	—	40
Admitted during the year	—	—	—	—	—	—	—	—	—	—	—	1	2	—	—	3
Died do.	—	—	1	—	—	1	—	1	1	—	—	—	1	—	—	5
Discharged do.	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
1896.																
Remaining in on January 1	10	1	—	1	1	—	1	18	1	1	—	2	1	—	—	37
Admitted during the year	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—	3
Died do.	3	1	—	—	—	—	—	—	—	—	—	—	1	—	—	5
Discharged do.	—	—	—	—	—	—	—	19	—	—	—	—	—	—	—	19[2])
1897.																
Remaining in on January 1	7	—	—	1	1	—	1	2	1	1	—	2	—	—	—	16
Admitted during the year	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	2
Died do.	1	—	—	—	—	—	—	—	—	—	1	1	—	—	—	3
Discharged do.	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	2[3])
1898.																
Remaining in on January 1	6	—	—	1	1	—	1	—	1	1	—	1	—	—	1	13
Admitted during the year	3	—	—	—	—	—	—	1	—	—	—	—	—	—	—	4
Died do.	1	—	—	—	—	—	—	—	—	1	—	1	—	—	—	3

1) Of European descent.

(B.) Return showing Particulars of Lepers detained at

Name	Sex.	Native of	Occupation	Admission	
				Age on	Date of
A. H.	Male	China	Gardener	42	19. April 1883
J. H.	do.	do.	do.	32	19. „ „
A. H.	do.	do.	do.	34	12. June „
A. M.	do.	do.	Butcher	32	28. Oct. „
A. P.	do.	do.	Storekeeper . . .	27	28. „ „
G. H.	do.	do.	Labourer	37	27. „ 1884
K. K.	do.	do.	do.	24	21. Dec. „

1) These are all natives of New South Wales, of European descent. 2) Date of report. This patient was afterwards removed to Little Bay. 3) This patient was transferred to a Hospital for the Insane on 2nd April, 1885, where also his death occured. 4) See note 1) to Appendix A.

	Natives of—														
	New South Wales	Queensland	New Zealand	Fiji	New Hebrides	NewCaledonia	Java	China	India	Germany	Belgium	England	Ireland	West Indies	U.S.A.	Total
1899.																
aining in on January 1	8	—	—	1	1	—	1	1	1	—	—	—	—	—	1	14
itted during the year	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
do.	1	—	—	—	—	—	—	—	1	—	—	—	—	—	—	2
1900.																
aining in on January 1	8	—	—	1	1	—	1	1	—	—	—	—	—	—	1	13
itted during the year	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
do.	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
1901.																
aining in on January 1	5	—	—	1	1	—	1	2	—	—	—	—	—	—	1	11
itted during the year	2	—	—	—	1	—	—	2	—	1	—	2	—	—	—	8
do.	2	—	—	1	1	—	—	1	—	—	—	—	—	—	—	5
1902.																
aining in on January 1	5	—	—	—	1	—	1	3	—	1	—	2	—	—	1	14
itted during the year	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	1
do.	—	—	—	—	—	—	—	1	—	—	—	1	—	—	—	2
harged do.	2	—	—	—	1	—	—	—	—	—	—	—	—	—	—	3
aining in, Dec. 31, 1902	3	—	—	—	—	—	1	3	—	1	—	1	—	—	1	10

Summary of cases since 1883.

	New South Wales	Queensland	New Zealand	Fiji	New Hebrides	NewCaledonia	Java	China	India	Germany	Belgium	England	Ireland	West Indies	U.S.A.	Total
l admitted since 1883	21	1	1	1	2	1	1	37	2	2	1	4	2	1	1	78
l died since 1883 . .	15	1	1	1	1	1	—	13	2	1	1	3	2	—	—	42
l discharged since 1883	2	—	—	—	1	—	—	21	—	—	—	1	—	1	—	26
aining in, Dec. 31, 1902	4	—	—	—	—	—	1	3	—	1	—	—	—	—	1	10

2) Returned to China, 14th August, 1896.
3) Returned to China, 17th July, 1897.

:tle Bay, New South Wales, since the year 1883.

Where from	No. of Case in Clinical Notes	Died or Discharged
ramatta Asylum .	—	Died 15. May 1886.
do. .	—	„ 27. June 1886.
do. .	—	„ . 20. April 1886.
terfield	XIV	} Returned to China, 14. August 1896.
low Creek	XV	} Returned to China, 14. August 1896.
.ney	—	4) Died 24. Decembre 1886.
hurst	—	„ 28. April 1885.

Notes: (*a*) The cases of a few other persons who, for one reason or other, were r admitted to the lazaret, have been mentioned in the course of this series of rts, and are additional to those shown in this Table. (*b*) On comparison with reports for early years, differences in ages or dates of admission of some coloured nts will be observed. Those now given are the correct ages and dates.

Where from	No. of Case in Clinical Notes	Died or Discharged
Bermagui	—	[5])Discharged 29. Decembre 1885.
Sydney	—	Died 6. February 1890.
Alexandria	XVI	Returned to China, 14. August 1896.
Cooper's Creek . . .	—	Died 12. Novembre 1890.
Castle Hill, Parramatta	XVII	—
Bathurst	—	Died 12. April 1891.
Sydney	XVIII	Returned to China, 14. August 1896.
do.	I	Died 25. Septembre 1892.
Inverell	XIX	Returned to China, 14. August 1896.
Sydney	XX	
Enfield	XXI	
Mudgee	II	Died 13. May 1894.
Richmond River . . .	III	„ 19. May 1901.
Balmain	IV	Discharged 1. May 1895.
Sydney	V	Died 1. May 1898.
Newtown	VI	„ 4. February 1891.
Newcastle	XXIII	„ 28. Decembre 1895.
Surry Hills	VII	„ 20. June 1892.
Narrandera	XXV	Returned to China, 14. August 1896.
Sydney	XXIV	
Mudgee	XXII	
Clarence River . . .	XXVI	Died 7 May 1901.
Narrabri	VIII	„ 27. March 1896.
Waverley	IX	„ 16. June 1899.
Sydney	XXVII	„ 29. „ 1892.
Gunnedah	X	„ 17. August 1900.
Sydney	XI	„ 28. May 1898.
do.	XXVIII	Returned to China, 14. August 1896.
North Sydney . . .	XII	Died 23. July 1897.
Manly	XXIX	Returned to China, 14. August 1896.
Sydney	XIII	Died 26. January 1901.
Bombala	XXXI	Returned to China, 17. July 1897.
do.	XXXII	Returned to China, 14. August 1896.
Sydney	XXXIII	Died 2, Aug. 1893
Parramatta	XXX	Returned to China, 14. August 1896.
Sydney	XXXIV	
Parramatta	XXXV	
Fiji	XXXVI	Died 10. Septembre 1895.
Cooma	XXXVII	Returned to China, 14. August 1896.
Parramatta Asylum .	XXXVIII	Died 4. April 1896.
Balmain	XXXIX	„ 13. March 1896.
Newcastle	XL	„ 22. „ 1899.
West Maitland . . .	XLI	„ 21. Septembre 1900.
Sydney	XLII	„ 8. July 1898.
do.	XLIII	„ 29. Novembre 1896.
do.	XLIV	„ 1. Septembre 1895.
do.	XLV	Discharged 5. Septembre 1902.
do.	XLVI	Died 2. August 1895.
Coast Hospital . . .	XLVIII	„ 6. Novembre 1897.
Sydney	LIII	„ 8. „ 1895.
do.	LII	„ 8. „ 1896.

never admitted to the lazaret, have been mentioned in the course of this series of Reports, and are additional to those shown in this Table. (*b*) On comparison with the reports for early years, differences in ages or dates of admission of some coloured patients will be observed. Those now given are the correct ages and dates.

Name	Sex.	Native of	Occupation	Admission	
				Age on	Date of
H. J.	Male	China	Hawker	31	21. Jan. 1896
H. Y.	do.	do.	Gardener	26	4. Febr. „
A. T.	do.	do.	do.	31	25. Dec. „
F. R.	do.	Belgium	Mechanic	55	16. Febr. 1897
H. W.	do.	U.S.A.	Mariner	57	12. Nov. „
[1]) W. W.	do.	N.S.W.	Labourer	19	26. Febr. 1898
[1]) A. B.	do.	do.	do.	20	22. March „
[1]) R. C.	do.	do.	Butcher	27	9. July „
A. G.	Female	China	Housewife	38	23. Sept. „
[1]) J. F. D.	Male	N.S.W.	Labourer	26	11. July 1899
C. P.	do.	China	Sculleryman . . .	22	14. April 1900
B. A.	do.	Aoba Island	Labourer	35	26. Febr. 1901
C. T.	Female	Germany	Housewife	29	23. April „
[1]) D. N.	Male	N.S.W.	Labourer	18	4. June „
J. S.	do.	do.	Farmer	52	20. „ „
[1]) D. L.	do.	England	Labourer	46	20. „ „
F. H.	do.	do.	Seaman	75	4. July „
A. R.	do.	China	Labourer	25	30. Oct. „
A. T.	do.	do.	do.	35	4. Dec. „
G. Y.	do.	do.	Miner	—	8. Jan. 1902

1) These are all natives of New South Wales, of European descent. 2) Date of report. This patient was afterwards removed to Little Bay. 3) Of European descent. 4) See note 1) to Appendix A.

Notes: (*a*) The cases of a few other persons who, for one reason or other, were

(C).

Clinical and Aetiological Note of the Patient admitted during the year 1902.[1])

By J. Ashburton Thompson, M.D., D.P.H.

Case LXXVII. — Gin Yung, m.. aet (?); admitted, 8th January, 1902.[2])

State on admission. — Is poorly nourished, and in feeble health. There is wasting of the small muscles of both hands, with loss of power, and anaesthesia;

1) Confusion between the date of report and the date of transfer from observation to the lazaret under the Board's warrant led to inclusion of this case in the Report for 1901 which, accordingly, should be corrected by subtraction of one Chinese. The case is now properly placed, and the Tables have been adjusted. 2) This patient was admitted and died during my absence from the State.

Where from	No. of Case in Clinical Notes	Died or Discharged
Coast Hospital . . .	LV	Returned to China, 14. August 1896.
do. . . .	LIV	
Oxley	LVI	Returned to China, 17. July 1897.
Coast Hospital . . .	LVIII	Died 23. June 1897.
Lord Howe Island . .	LIX	
Wollongong	LXI	„ 21. February 1900.
Gunnedah	LXIV	„ 7. July 1901.
Wollongong	LXII	
Waterloo	LXVI	„ 4. February 1901.
Lismore	LXVII	
Sydney '.	LXVIII	
Murwillumbah . . .	LXIX	Returned to Aoba, 1. Decembre 1902.
Lismore	LXX	
Glen Innes	LXXI	
Miller's Forest . . .	LXXII	Discharged 28. February 1902.
Rookwood Asylum . .	LXXIII	Died 15. Decembre 1902.
Sydney	LXXIV	
do.	LXXV	
do.	LXXVI	
do.	LXXVII	„ 17. January 1902.

never admitted to the lazaret, have been mentioned in the course of this series of Reports, and are additional to those shown in this Table. (*b*) On comparison with the reports for early years, differences in ages or dates of admission of some coloured patients will be observed. Those now given are the correct ages and dates.

there is considerable contraction of all fingers; some thickening of the ulnar nerves, especially the left; on tho left arm is a narrow band of anaesthesia, bounded by a pinkish, scaly margin, following the course of the musculo-spiral nerve. The terminal phalanx of the left thumb has disappeared. There is a similar condition of the legs, with marked wasting; anaesthia below the knees, and trophic changes in the toes (which are contracted) and toe-nails. There is an area of anaesthesia on the front of the left thigh and knee, pale in centre, and bounded by pinkish, scaly borders. The terminal phalanx of the left big toe has disappeared. There are two or three anaesthetic areas on the lower part of the back.

Although there is no statement as to this patient's age, his death (which occurred about a week after his admission) was ascribed to senile decay.

Nord-Amerika.

Bericht

von

Isadore Dyer in New-Orleans.

Introduction.

Guided by the following letter[1]) of advice from the esteemed Secretary for America of the International Dermatological Congress the writer began at once to solicit the desired information both by circular letters and by personal request of all who might be interested. Where possible

1. Foot Note. February 3rd, 1904.

Dr. Isadore Dyer,
124, Baronne Street,
New Orleans, La.

Dear Dr. Dyer: —

I am pleased to learn from yours at hand of your consent to report at the Fifth International Dermatological Congress on the subject of Leprosy in North America.

I shall be pleased if you will kindly make your report conform as far as possible to the scheme presented by the Administration of the Congress, which has been formulated by Prof. von Petersen and forwarded to me, and which is presented below.

Truly yours,
(Signed) James Nevins Hyde,
Secretary for America.

1. Statistik.
   a) nach offiziellen Berichten.
   b) der Asyle, Kolonien.
      (Form, Geschlecht, Alter.)
2. Massregeln zur Bekämpfung der Lepra v. 1897—1903 inkl.
   a) Regierungsverordnungen,
   b) Tätigkeit der Regierungsorgane resp. Gesellschaften zur Bekämpfung der Lepra, Kommunen, etc.
      1. Zahl der Asyle oder Kolonien.
      2. Zahl der Plätze.
      3. Krankenbewegung.
      4. Beschäftigung der Leprösen in Anstalten.
      5. Transport der Leprösen in die Anstalten per Eisenbahn bezw. Dampfer.
3. Die Lage der Leprösen in den Hospitälern und Kliniken.

personal letters were sent to individuals living in countries or localities known to be affected with leprosy. The Circulars[2])[3]) were sent to.

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1. Foot Note. New Orleans, March 12th, 1904.

My dear Sir; —

I have been asked to prepare a report on Leprosy in North America to be presented at the International Dermatological Congress in Berlin next September. I am desirous of making this report as complete as I possibly can, and to this end I am addressing every known leper centre in British North America, Mexico, the West Indies and the United States.

Here and there sporadic cases have been reported and I whish to include these in making my report.

Aside from the detail of locating points at wich cases have occurred I am anxious to have opinions regarding the probable origin of the disease; the general conditions of climate in the state or country where it occurred; the principal articles of food, the particular surroundings of the patient affected.

Heretofore reports which have gone from this country have been written by men outside of leper centres. and my personal opinion is that no report as yet has been sufficiently searching and complete. I am quite in earnest in wishing to have the fullest possible data so that in the meeting which is to take place next September I can personally present not only information with regard to the appearance and occurrence of the disease, but also can quote you in an authoritative way as to your views concerning the disposition of these cases and the apprehension as to spread, contagion, etc.

As I am writing to a great many men for the purpose of getting the fullest possible authoritative information, I trust that you will give this communication the highest consideration it may deserve at your hands.

I expect to sail for Europe in June so should be glad if you could send me your reply on or before May 15th.

I append the official points of query but desire that you write as fully as possible so that I may be able to compile your opinions and to give you full credit for them in my report when published.

Thanking you in advance for the courtesy of your assistance,

I am,

Cordially yours,
Isadore Dyer.

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2. Foot Note.

Official information desired.

1. Statistik.
   a) nach offiziellen Berichten,
   b) der Asyle, Kolonien.
   (Form, Geschlecht, Alter.)
2. Massregeln zur Bekämpfung der Lepra v. 1897—1903 inkl.
   a) Regierungsverordnungen,
   b) Tätigkeit der Regierungsorgane resp. Gesellschaften zur Bekämpfung der Lepra. Kommunen, etc.
      1. Zahl der Asyle oder Kolonien.
      2. Zahl der Plätze.
      3. Krankenbewegung.
      4. Beschäftigung der Leprösen in Anstalten.
      5. Transport der Leprösen in die Anstalten per Eisenbahn resp. Dampfer.
3. Die Lage der Leprösen in den Hospitälern und Kliniken.

Translation.

1. Statistics.
   a) According to official Reports,
   b) Asylums, Colonies.
   (Form, Race, Age.)
2. Measures against Leprosy 1897—1904. incl.
   a) Government Regulations.

1. The President and to the Secretary of the Board of Health of each State and Territory, and additionally to the President and Secretary of the Board of Health in each City of each State where the population justified the belief that some record of leprosy might have been kept. Letters were sent also to every member of the American Dermatological Association, as being perhaps most often cognizant of the disease.
2. Letters and Circulars were sent to the several Governmental heads of Mexico, the West Indian Islands, & to the several provinces in Canada, where these could be ascertained:

As the chief object of the Congress seems to be the determination of the effect of the 1897 Berlin Lepra Conference on governmental and other relations in the management of leprosy, and as the lines of information are succinctly given we shall briefly submit the information derived arranged according to the plan directed with such additional observations as the occasion may demand. —

I. The United States.

A. Considered in its governmental relation to Leprosy in the States and territories, excluding the Pacific Islands.

B. Considered by States as each may have supplied information either through the official Health Officers, or through individuals living in the State who may have become cognizant of the disease.

A. At the conclusion of the Berlin Conference in 1897 the only Governmental relation to leprosy was that of Quarantine restriction, which forbade the admission of a leper and compelled the carrier to deport the leper to the country from which he or she came. This law became effective in 1894. In 1903 the law was modified and the scope very much extended, viz:

U. S. Quarantine Regulations.

Revised 1903.

p. 29. „Special Regulations on account of Leprosy."

p. 122. Vessels arriving at quarantine with leprosy on board shall not be granted pratique until the leper with his or her baggage has been removed from the vessel to the quarantine station.

p. 123. No alien leper shall be landed.

p. 124. If the leper is an alien passenger, and the vessel is from a foreign port, action will be taken as provided by the immigration laws and regulations of the United States. And to this end

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b) Efficiency of the Government organ in Lepra centres.
1. Number of Asylums or Colonies.
2. Number of places (centres).
3. Movement of the sick (Krankenbewegung).
4. Occupation of Lepers.
5. Transportation of lepers to Institutions, by rail or boat.

3. Condition of Lepers in the Hospitals and Clinics.

the case shall be certified as a leper, and reported to the nearest commissioner of immigration.

p. 125. If the leper is an alien and a member of the crew and the vessel is from a foreign port, said leper shall be detained at the quarantine at the vessel's expense until taken aboard by the same vessel when outward bound. Such case of leprosy should be promptly reported to the collector of customs at the port of arrival of the vessel, and the collector shall exact a bond from the vessel for the reshipment of the said alien leper upon the departure of the vessel."

From various parts of the United States reports of leprosy arose and the press of the country at frequent intervals presented sensational accounts of the prevalence of the disease; wild stories of leprosy conditions in the Hawaiian and Phillipine Islands also gained currency. All of a sudden somebody remembered the Berlin Conference and a bill was introduced in the Senate of the United States Congress of January 22nd 1902[1]).

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1. Foot Note.

57th Congress,
1st Session.

S. 3094.

In the Senate of the United States.
January 22, 1902.

Mr. Platt, of New York, introduced the following bill; which was read twice and referred to the Committee on Public Health and National Quarantine.

A BILL

To provide for a national leper law for the suppression and prevention of leprosy in the United States of America.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled. That to carry out the intention of the Berlin Lepra Conference, which had for its object to bring to the attention of every government the evident spreading of leprosy in every country where isolation is not practiced, and the danger to civilized communities by the insidious inoculation through unrestrained movement of lepers among their own people and from one country to another, that a commissioner on leprosy be appointed by the President, by and with the advice and consent of the Senate, his term of office to be of five years. He shall be a regularly educated physician, holding a diploma conferred upon him by a legally incorporated medical college in the United States. He shall reside at New York or San Francisco. He shall have had at least ten years of general experience in the practice of medicine and a particular experience in a leper community. He shall be entitled to a salary of five thousand dollars per annum, to be paid to him by the Secretary of the Treasury on the first of each and every month pro rata. He shall call to meet annually the presidents or executive officers of all the State boards of health, their necessary traveling expenses being paid by the Secretary of the Treasury.

Sec. 2. That a mile square (six hundred and forty acres of land) shall be set aside for the location of a national leper home in some part of the public domain far from the Atlantic and Pacific coast lines, where the climate is dry and antagonistic to the life of the leper bacillus; the site to be chosen by a board of leprologists, consisting of the national commissioner of leprosy and four experts in leprosy to be appointed by the State boards of health of Louisiana, Minnesota, California, and Florida.

Sec. 3. That an appropriation of fifty thousand dollars is hereby made for the purpose of erecting suitable buildings for the habitation of the lepers of the United

There was almost no attention given to this bill beyond medical journal notice, and it is still „lying on the table“ since 1902.

Shortly after this bill was pigeonholed another Bill was introduced and was promptly enacted. —

Porto Rico.

The United States Government has established a hospital at San Juan where 17 of 75 reported cases are segregated. This hospital is under the direction of a Board of Charities and is not evidently a hospital for segregation under indictment or restriction other than hospital rules.

Mischellaneous Resolutions.

Several Medical Associations from time to time memorialized Congress, notably the States of Iowa and Minnesota; but especially the American Public Health Association which, for the second time, in 1902, at their New Orleans Meeting, adopted resolutions directed at the establishment of National leprosaria under the best of conditions. In the report of Dr. H. M. Bracken, of Minnesota, which led to the resolutions some reference was made to the conditions of leprosy generally in the U. S. and neighbouring countries.

States, not including those of Hawaii, Porto Rico, Cuba, or the Philippines, in accordance with the plans to be drawn and approved by the commissioner of leprosy to be appointed by the President, and for the support of the lepers received from the different State boards of health.

Sec. 4. That it shall be unlawful for any State board of health knowingly to keep or allow to be kept within its jurisdiction any leper, unless such leper is isolated in a special asylum away from patients suffering from other diseases, or to permit such leper, if able to take care of himself or if he is taken care of by his family, to remain in his family or with strangers in the household otherwise than under the strict supervision of the State board of health, approved by the national commissioner of leprosy. In no case shall such leper be permitted to reside in any public boarding house, hotel. or eat at a public restaurant. His clothing is to be kept apart and his washing to be done separately. In no case shall his clothes be washed in a public laundry. He must use and wash his own eating utensils, sleep alone unless married, and have no bodily contact, such as kissing, and so forth, with any other member of his family. It shall be the duty of the State board of health, approved by the national commissioner, by strict supervision to enforce the observance of these rules.

Sec. 5. That lepers unable to care for themselves must be turned over to the national commissioner of leprosy, who shall cause them to be transported to the national leper home at the cost of the National Government.

Sec. 6. That it is recommended to all State boards of health, but not compulsory, to turn over all their lepers, the well-to-do as well as the poor, if possible, to the national commissioner.

Sec. 7. That it shall be unlawful for any steamship company or other vessel or railroad to bring to the United States any leper, or to accept any emigrant from any of the countries known to be leprous, to wit, especially Canada, Mexico, Hawaii, Japan, China, India, Spain, Portugal, Norway, Sweden, Finland, Russia, Iceland, West Indies, the States of South America, without a special certificate of health from the Government state board of health of the emigrant's country, countersigned by the United States consul and the Marine Hospital surgeon attached to the consulate of the country at the emigrant's port of embarkation.

Sec. 8. That emigrants of known leprous family, but free of the disease themselves are to be kept under strict supervision by the local boards of health in the United States for a term of seven years, at the end of which time, if no leprosy has developed, they are to be free of any further supervision.

Observations.

The entirely political nature of National legislation at Washington unfortunately colors even humanitarian measures. When the general indifference of health authorities themselves is taken into consideration it is not hard to understand why the Congress, made up of politicians, should fail to pass health laws when they are neither urged nor forced to do so.

Some of the individual states of the United States have taken earnest interest as may be seen below.

B. The United States considered along the lines of query taken State by State in alphabetic order.[1])

Alabama.

Source of Information. No reply received from any person addressed, official or otherwise.

Sec. 9. That should a leper enter the United States in spite of these precautions, it shall be the duty of the local State board of health to have him or her sent back by the consul of his or her country at his port of disembarkation.

Sec. 10. That in the operation of this national leper law no discrimination shall be made between a citizen of the United States who has contracted leprosy in the United States and a foreigner who has contracted the disease in a foreign country.

Sec. 11. That the Marine-Hospital Service of the Treasury Department of the United States shall have full charge of the national leper home.

2. Foot Note.

Legislation U. S. Congress.

The following Bill was prepared and presented to Congress. Surgeon-General Wyman writing to Hon. G. G. Vest stating that fresh cases are constantly being noticed and the disease spreading in more than one locality. He stated his belief that more cases than are known actually exist and urged the investigation:

A Bill for the investigation of Leprosy.

"Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled. That the supervising Surgeon-General of the Marine-Hospital serving under the direction of the Secretary of the Treasury, shall appoint a commission of medical officers of the Marine Hospital Service to investigate the origin and prevalence of leprosy in the United States, and to report on or before December 1st next what action is necessary for the prevention of the spread of this disease, the expenses of this investigation to be paid from the fund for preventing the spread of epidemic diseases."

The Committee on Public Health and National Quarantine to whom the bill was referred and of which G. G. Vest was chairman, for the reasons stated by Surgeon-General Wyman in his letter to Vest, recommended the passage of the bill.

The Marine Hospital Service began its work promptly with a commission headed by Dr. J. H. White, of the Service. Their results have been published and when digested show a hurried fulfilment of the letter of the law and an exhaustive (?) report on leprosy in the United States after a few months epistolary examination. A total of 278 cases was discovered, 155 cases being reported from Louisiana alone, leaving a total of 123 in the whole of the United States outside of Louisiana!

As yet no further action has been taken by Congress and there is no evidence of any to be taken in the near future.

1) Only those States are given where either afliciae reply was had, or where leprosy, was known E. Geist. P.

Laws.

Alabama has no asylums for lepers and has no laws directed at this disease.

Statistics.

One case of leprosy in mobile — Female — mixed type, came under Dr. Dyer's personal observation in 1904.

Arkansas.

No information furnished by authorities.

No law in force. At least for cases of leprosy known to have been at Hot Springs between 1897 and 1904.

California.

In a letter received from

Source of Information.

Dr. N. K. Foster, Secretary of the State Board of Health the following information was supplied.

„We have no statistics in this office in regard to lepers and the State has no lazaretto. There are a few cases, one in Los Angeles County, one in San Bernardino Co., and perhaps 5 or 10 in San Francisco Co."

The Health authorities of San Francisco did not reply to circular.

Miscellaneous cases have been reported during several years past, and not long ago (in 1902) Montgomery reported 17[1]).

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1) San Francisco, Cal., July 22, 1904.

Dr. Isadore Dyer,
124 Baronne St.,
New Orleans, La.

Dear Dr.: —

Inclosed please find the list of the lepers of whom I have histories. This does not, by any means, include all the lepers in San Francisco, and some of these in this list are dead. This is however, the best I can do at the present. I remain,

Yours sincerely,

Douglass W. Montgomery.

1. Chang Kim, male, Chinaman, aet. 25, History first taken, March 1, 1892, Tubercles, macules, dactylitis, leucodermia.
2. Dang Hung Kuen, male, Chinaman, aet. 44, History first taken, Dec. 31, 1891, Anaesthesia, macules, tubercles, enlarged nerves.
3. H. P. L., male, Swede, aet. 48, History first taken, Apr. 28, 1892, Tubercles, enlarged nerves, chagreened skin.
4. S. M., male, Hindoo, aet. 69, History first taken, Nov. 18, 1894, Enlarged nerves, anaesthesia, contracted fingers, ankylosed joints, mutilated phalanges.
5. Chan Muy, female, Chinawoman, aet. 29, History first taken, Dec. 24, 1891, Tubercles, clawed hands, mutilated fingers.
6. Ah Nam, Chinaman, aet. 36, History first taken, Feb. 16, 1896, Macules.
7. Yce On, male, Chinaman, act. 23, History first taken, Mar. 18, 1897, Tubercles, chagreened skin.
8. R. P., male, Mexican, aet. 19, History first taken, Sept. 24, 1899, Enlarge- nerves, chagreened skin, macules.
9. S., male, Finn, aet. 43, History first taken, Dec. 19, 1891, Macules, swellin of nerves, tubercles, clawed hands, mutilated phalanges.
10. Miss W., female, Chinese half-breed, born in Honolulu, H. I. aet. 2 History first taken, Sept. 27, 1900, Enlarged nerves and other nervous symptom

Dr. Wm. F. Breakey, at the University of Michigan, writes me in April to say that last year (1903) he saw „about twenty cases in the leper Colony in San Francisco."

No systematic tabulation of cases has been made since Orme's report in 1890 (Pr. Med. Society of California) — when there was already a law covering the reporting of the disease.

The San Francisco pesthouse reports give some statistics but these have not been accessible for several years.

Legislation.

California passed laws regarding leprosy in 1892, which seem to have covered the ground very thoroughly, but the absence of State

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11. Ma Yen, male, Chinaman, aet. History first taken, Feb. 12, 1894, Leucodermia, clawed fingers sunken metacarpal interspaces.
12. Lee Yen, male, Chinaman, aet. 33, History first taken, Dec. 24, 1893, Leucodermia, macules, tubercles.
13. Ugo Wong, male, Chinaman, aet. 30, History first taken, Oct. 19, 1893, Tubercles, macules, chagreened skin.
14. V. A., male, Swede, aet. 39, History first taken, July 9, 1900, Anaesthesia, macules.
15. L. A., male, white, born in Hawaii, aet. 23, History first taken, Dec. 1, 1893, Anaesthesia, tubercles.
16. J. B., male, Scotch, aet. 67, History first taken, Feb. 13, 1900, Anaesthesia, macules, enlarged nerves, sunken metacarpal interspaces.
17. P. B., male, Mexican, aet. 16, History first taken, Dec. 10, 1891, Hyperaesthesia, macules, tubercles, enlarged nerves.
18. Mrs. F. C., female, Irish, aet. 45, History first taken, Dec. 18, 1890, Macules, tubercles.
19. E. B., male, white, born Hawaii, aet. 22, History first taken, Oct. 19, 1893, Anaesthesia, enlarged nerves, clawed hands, dactylitis.
20. F. B., male, white, born in Hawaiian Ids., aet. 29, History first taken, Oct. 29, 1898, Macules, anaesthesia.
21. Chung Kan Foke, male, Chinaman, aet. 31, History first taken, Feb. 5, 1894, Tubercles.
22. Yee Foo, male, Chinaman, aet. 36, History first taken, March 18, 1897, Tubercles, atrophied phalanges, vitiligo.
23. Lung H., male, Chinaman, aet. 27, History first taken, March 18, 1897, Macules, sunken metacarpal spaces.
24. J. B., male, Mexican, aet. 48, History first taken, Apr. 8, 1903, Tubercles, anaesthesia.
25. L. S., male, American, aet. 68, History first taken, Feb. 10, 1903, Anaesthesia, perforating ulcer.
26. H. J., male, American, aet. 34, History first taken, 1883, Macules, anaesthesia.
27. Hoo Sing, male, Chinaman, aet. 46, History first taken, Aug. 13, 1903, Tubercles, chagreened skin.
28. Mrs. V., female, German, aet. 56, History first taken, July 23, 1901, Tubercles, macules.
29. Sam Fook, male, Chinaman, aet. 37, History first taken, May 20, 1897, Tubercles, enlarged nerves.
30. Leong O. You, male, Chinaman, aet. 45, History first taken, Dec. 29, 1897, Neural chagreened skin, clawed fingers.
31. Loui Gen, male, Chinaman, aet. 24, History first taken, Dec. 29, 1897, Tubercles, macules, chagreened skin, paralysed fingers, anaesthesia.
32. G. P., male, German, aet. 32, History first taken, Nov. 17, 1896, Tubercles, mutilated toes, anaesthesia.
33. Quan Chew, male, Chinaman, aet. 44, History first taken, Dec. 29, 1897, Atrophied muscles, macules, anaesthesia.

Board of Health reports, and the absence of any obtainable official statistics shows that the letter and spirit of the law are both buried.

Here is the law:

(Sec. 2952) It shall not be lawful for lepers or persons affected with leprosy or elephantiasis, to live in ordinary intercourse with the population of this state: but all such persons shall be compelled to inhabit such lazarettos or lepers' quarters as may be assigned to them by the Board of Supervisors of the city or county in which they shall be domiciled or settled; and the Board of Supervisors are vested with power and are required to make all necessary provisions for the separation, detention, and care of lepers, or persons affected with leprosy or elephantiasis, settled or domiciled in their respective cities or counties. The Superintendent or Manager of all Lepers' Quarters under this chapter shall forward quarterly statements showing the name, age, sex, and birthplace of each leper in such quarter, to the Secretary of State, who shall keep a proper record of such matters for the information of the public. In effect March 25. 1876.)

Sec. 2955. The Commissioner of Immigration must satisfy himself whether or not any person who shall arrive in this State by vessel from any foreign port or place is a leper, or affected with the disease known as leprosy or elephantiasis before such person shall mingle with the population of this State. For the purpose of ascertaining said fact, the Commissioner is vested with the power and authority to detain such persons on board any such vessel so arriving, and to assign the vessel to a berth or anchorage separate and apart from other vessels, and at a safe and suitable distance from the shore, if in his judgement it shall be necessary, until such fact can be fully ascertained by him. Such fact shall be ascertained by personal inspection and examination of each and every person on board such vessel; and the Commissioner of Immigration is authorized, empowered, and required to make such personal inspection and examination of all persons so arriving by any such vessel, the same to be made at such berth or anchorage as he shall, in his discretion, assign to such vessel for that purpose, and shall be made before the landing of any person thereupon. All of such persons who, upon inspection and examination, are found to be lepers, or affected with the disease known as leprosy or elephantiasis, shall be taken in charge by the Commissioner of Immigration, and placed in a suitable lazaretto or lepers' quarters, to be provided or designated by the Board of Supervisors, whenever necessary for that purpose, as hereinbefore prescribed, and there detained and properly cared for, separate and apart from the general population of this State, so long as they, the said lepers, shall elect to remain in the State of California, or until they shall have recovered from the said disease, and no longer.

All of such persons as shall be found to be free from the said disease shall be allowed to depart and go at their will, without unnecessary detention or delay, and shall be entitled to receive a certificate of the fact of their freedom from said disease from said Commissioner. For his services in making such examination and inspection the Commissioner of Immigration shall demand and collect from the

master, owner, or consignee of such vessel the sum of seventy cents, in United States gold or silver coin, for each and every person so examined or inspected, which sum, except four thousand dollars a year and expenses of office, shall, when required for such purpose, be paid by the Commissioner into the State Treasury to be used in the maintenance, when necessary, of such lazerettos or lepers' quarters as shall be constructed under this law. Any master, owner, or consignee of any vessel arriving at any port of this State, who shall fail or refuse to perform, or permit the performance of, any of the acts or things required by this chapter, or to take and occupy with his vessel the berth or anchorage assigned for the same by the Commissioner pending the examination and inspection herein provided for or who shall permit or allow any person arriving in such vessel to depart therefrom and to communicate, mingle, or associate with the population of this State or any part thereof until after such examination and inspection by the Commissioner is had, shall for every such act or omission forfeit to the Commissioner of Immigration the sum of One thousand dollars in United States gold coin, to be sued for and recovered by suit in any court of competent jurisdiction, and to be applied in like manner with the fees, and any master, owner or consignee of any such vessel so arriving, who shall refuse or neglect to pay, or cause to be paid to said Commissioner, the fee of seventy cents for the examination & inspection of each and every person so arriving in such vessel, shall forfeit to the said Commissioner, for each case, the sum of five hundred dollars in United States gold coin, to be recovered and applied for as above. And the Commissioner shall have lien upon the vessel, and the same shall be sold to pay any judgement recovered under this act. The Commissioner shall have the power to call in the aid of the sheriff, and all police authorities to assist in enforcing this law. And he may appoint one or more deputies under him, who shall be vested with all the powers of the Commissioner, and may discharge his official duties when required by him. The Commissioner of Immigration must prepare and transmit to the Secretary of State quarterly statements, certified under his hand and seal, showing the name, age, sex, birth place, and present residence of every leper, or person affected with leprosy or elephantiasis, examined or inspected by him as well as any other information or fact touching the character and prevalence of said disease within his knowledge (in effect March 25th, 1876.)

(Sec. 2959.) For all Fines and Penalties imposed by this chapter upon any master or commander, owner or consignee, for any omission, neglect, or refusal to perform any act or duty required by this chapter, such vessel is liable, and the amount of such fines or penalties are a lien upon such vessel, and have priority over all other liens, except those for seamen's wages, bottomry bonds, and respondentia. Such penalties and fines may be sued for and recovered in a civil action, with costs of suit by the Commissioner, or by his authorized attorney, in the name of the people of the State of California, in any Court having cognizanze thereof, and when recovered must, after deducting the expenses, be paid into the State Treasury.

Sec. 2960.) The Commissioner may compound or commute, for

any of the penalties or fines, upon such terms as he thinks proper, and at the end of every month report to the Controller of the State the reasons and causes of such compounding or commutation . . .

(Sec. 2962.) Masters of vessels arriving in any of the ports of this State from any port in this State, or from Oregon or Washington territory are exempt from making the statement required by this chapter, when the vessels in which they arrive have not taken on board at their port of departure, or at any intermediate port, any other passenger, to be landed at the port of arrival: and masters of vessels arriving from Panama are also exempted from the provisions of this chapter, when they have not landed, or are not about to land, passengers who took their departure from ports other than the port of New York, and in no case must such master be required to report any passenger other than way passengers taken on board between the port of New York and the port of arrival in this State.

(Sec. 2963.) The Consuls, Ministers, agents, or other public functionaries of any foreign government, arriving in this State in their official capacity, are exempt from the provisions of this chapter.

(Sec. 2964.) The Commissioner of Immigration must approve all the bonds and administer all oaths required in the discharge of his duties. Whenever it appears that the Master or Commander of any vessel has not made a full and correct report, as provided by this chapter, the Commissioner must enquire into the same, and for that purpose may require the attendance of witnesses before him in the same manner as Notary Publics may in Civil cases. Testimony so taken may be read as evidence on the trial of any action commenced for any penalty or forfeiture accruing under the provisions of this chapter, in the same manner and with like effect, as if regularly taken in such action.

(Sec. 2966.) In all the parts of this State, other than San Francisco, the Mayor or chief Municipal officer at such port, then the Sheriff of that County, is ex-officio commissioner of immigration for such port, and in carrying out the provisions of this chapter, has all the powers and is liable to all the penalties provided herein.

(Sec. 2968.) The commissioner of Immigration for the port of San Francisco must execute an official bond in the sum of twenty five hundred dollars (in effect March 25 1876).

District of Columbia.

Dr. Wm. C. Woodward writes, under date of March 24: — „In 1896, when an effort was being made to secure the enactment of a law for the prevention of the spread of such diseases as cholera, yellow fever, small pox, etc., the word „leprosy“ was inserted as a convenient way of providing means for handling a case should one ever be discovered. No case, however, has yet come to hand.“

[One case of leprosy from Washington, D. C. was seen by the writer of this paper in 1904.]

Florida.

No official information received. Key West, Florida is known as a leper center and in 1890 was quoted by Berger as having 100 cases

large! (The easy intercourse with Cuba rather encourages belief in prevalence at Key West.)

Illinois.

1898. Lieberthal reports one case in a Greek.

1899. Edwards reports one case in an Englishman (Chicago ed. Recorder).

1902. Lieberthal reports one case in a Chinaman (Chicago ed. Recorder).

1904. Dr. J. Nevins Hyde writes: „We have had but three ses under our observation since 1900.“ Total 6 Cases.

Legislation.

No information could be obtained regarding State or City Legision, and the State officials ignored my communication.

Indiana.

Dr. J. N. Hurty, Secretary of the Indiana State Board of Health ites: „So far as this office is informed, no case of Leprosy has curred in Indiana. There is a large Norwegian colony at South nd, Indiana, and we have had it inspected, but without result so far leprosy is concerned.“

Iowa Legislation.

In 1898 Resolutions were passed by the State Board of Health verning Leprosy, the occasion being the discovery of 2 cases at land, and at Ridgway, Iowa. April, 1898. Resolved: „That it is e sense of this Board that while we recognize the fact that the ntagiousness of leprosy is an unsettled question, it is in our opinion st for the public health, that persons afflicted with well developed prosy should be required by all local health boards to remain on eir own premises, instead of being permitted to mingle with the neral public.“ — State Board of Health Report for 1899.

No official answers received and communications sent re ignored.

Kansas.

Secretary of Board of Health expresses ignorance regarding the estions involved.

Kentucky.

Dr. J. N. Mc Cormack, Secretary of the Kentucky State Board Health under date of March 22, 1904, writes: „I am very glad to orm you that we have had no experience with leprosy in Kentucky. e case was reported in Campbell County some ten years ago, but was a non resident, and left before our inspector reached the county.

Legislation.

No information given.

Dr. J. N. Bloom, of Louisville, reports a case of anesthetic prosy in a male aged 39, born in Illinois and living in Kentucky nce 188. (Louis. Monthly Journal of Med. and Surgery, 900—01, VII. 368.)

Louisiana.

In 1894 the present Louisiana Leper Home was established and since it began has fulfilled the chief object of maintaining public interest in the question of leprosy in the State. It began as a hospital and asylum. From 1896 to 1901, however, the home was conducted purely as an asylum and in nowise obtained the support of the medical profession. In 1902 a regular system of treatment was begun under the supervision of a visiting staff, and the result has been evident. The number of inmates has increased and the whole atmosphere of the Home has improved. The establishment of the Home anticipated the Berlin Conference of 1897, and the direct effect of the work of that Conference has been evident chiefly in the methods of sanitation, segregation and treatment observed.

The Reports of Dr. Ralph Hopkins, physician to the Home, for 1902 and 1904 give a fair idea of the condition of the inmates admitted during his service. In 1897, I reported 131 living cases of Leprosy in Louisiana, of which thirty-six (36) were inmates of the Louisiana Leper Home. In 1902 there had been admitted a total of 62 cases, and there were then (May, 1902) 38 living. From 1902 to May 1904 at the Home the total of admissions was increased to 80. The summary of the cases in the Home from May 1, 1902 to April 28, 1904 follows:

Lousiana Leper Home. — May 1st 1902 to April 28th 1904.

No.	Admitted	Form	Race	Sex.	Age	Condition	Remarks
1	Dec. 1. 1894 (brother died of leprosy)	Mixed	White	Male	43	Statu quo.	Keeps in fair general condition.
2	Dec. 1. 1894	do.	do.	do.	25	Advanced.	—
3	Dec. 1. 1894	do.	do.	do.	28	Died (1902).	Mother died of leprosy.
4	Dec. 1. 1894	do.	do.	Female	24	Died 1902.	—
5	Mar. 26. 1895	Anaesthetic	do.	do.	16	Statu quo.	Lesions are getting less evident.
6	Apr. 20. 1895	do.	do.	Male	44	Died 1902.	—
7	Aug. 15. 1895	do.	do.	Female	41	Improved.	—
8	Aug. 15. 1895	Mixed	Negro	do.	25	Died 1902.	—
9	Nov. 9. 1895	do.	White	do.	30	Improved.	9, 10, 11 all sisters and another sister who died previously at home
10	Nov. 9. 1895	do.	do.	do.	20	Died 1902.	—
11	Nov. 28. 1895	Anaesthetic	do.	do.	13	Improved.	—
12	Mar. 1896	Tubercular	do.	Male	10	Much improv.	—
13	Mar. 4. 1896	Anaesthetic	do.	do.	30	Trophic evidences.	—
14	Jany. 29. 1897	do.	Negro	do.	50	No improvement.	—
15	May 1. 1897	Mixed	White	Female	11	Advanced.	—
16	May 16. 1897	do.	do.	Male	12	Improved.	—

Admitted	Form	Race	Sex.	Age	Condition	Remarks
May 1897	Mixed	White	Female	13	Died 1903.	Father was a leper. Now dead.
June 1898	do.	do.	do.	13	Died 1903.	Mother and one brother were lepers.
Oct. 11. 1898	Anaesthetic	do.	Male	60	Died 1903.	—
Oct. 24. 1898	Mixed	do.	do.	18	Improved.	—
Feby. 1899	Tubercular	do.	do.	22	Much improv.	—
Aug. 10. 1899	Anaesthetic	do.	Female	50	Improved.	One son and two cousins lepers.
Aug. 10. 1899	Mixed	do.	Male	24	Improved.	Son of 22.
Aug. 26. 1899	Anaesthetic	do.	do.	33	Much improv.	—
April 29. 1901	Tubercular	do.	do.	50	Worse.	Only case in Home not originating in La.
June 21. 1901	Anaesthetic	do.	do.	15	Improved.	Mother died of leprosy No. 27 — Seq.
June 1901	Mixed	do.	Female	19	Died of lepra fever.	—
June 1901	do.	do.	Male	28?	Improved.	Absconded.
June 21. 1901	do.	Negro	Female	20	Not improv.	Will take no medicine.
Aug. 22. 1901	Anaesthetic	do.	do.	about 40	Improved.	—
Oct. 3. 1901	Tubercular	White	Male	35	Died 1903.	—
Nov. 20. 1901	do.	do.	do.	28	—	—
Nov. 30. 1901	Anaesthetic	do.	Female	10	Died.	Insane.
No record kept Patient absconded			—	—	—	—
1901	Tubercular	White	Male	37	Improved.	—
Mar. 1. 1902	do.	do.	do.	39	Excellent.	—
Mar. 11. 1902	do.	do.	Female	37	Improved.	—
Absconded in greatly improved condition July 18. 1902						—
1902	Tubercular	White	Female	36	Much improv.	—
June 18. 1902	do.	do.	Male	16	Better.	—
Aug. 26. 1902	do.	do.	do.	26	Much improv.	—
Oct. 1902	do.	do.	do.	13	Discharged cured.	—
Oct. 1902	do.	do.	do.	13	Very much. improved.	—
April 7. 1903	do.	do.	do.	12	Very much. improved.	—
May 1903	Anaesthetic	do.	Female	49	Died March 1904.	—
June 30. 1903	Tubercular	Negro	Male	16	Much improv.	—
July 1. 1903	do.	White	Female	59	Improved.	—
July 24. 1903	Mixed	Negro	Male	55	Died 1903.	—
Absconded Nov. 5. 1903		—	—	—	—	—
Sept. 12. 1903	Tubercular	Negro	Male	27	Statu quo.	—
Jan. 13. 1904	Anaesthetic	White	Female	45	Improved.	—
Feby. 5. 1904	Tubercular	do.	Male	24	No improvement.	—
Mar. 23. 1904	Macular Anaesthetic	do.	Female	45	—	Mother and daughter.
Mar. 23. 1904	Macular Anaesthetic	do.	do.	19	—	—

Louisiana.

This represents the present conditions at the home. Since this last report was published three new cases have been admitted. From 1897 to 1902 comparatively little was accomplished at the home save in a domestic way. Now there are all evidences of a better state of affairs. New cottages have been erected for the female patients and these have been separated according to type and severity of evidences. Each cottage has accommodation for as many as 10 patients, and each cottage is provided with ample facilities for bathing, which is made compulsory under sanitary and hygienic as well as antiseptic arrangements.

As yet the male members of the Home are inadequately provided for; but the incumbent Board of Control has succeeded at the last Session of the Louisiana State Legislature in obtaining a large appropriation for their needs.

Officially then in Louisiana.

1. There is one Leper home or asylum in the State, situated at Indian Camp Plantation, on the Mississippi River, about 80 miles from New Orleans and in communication by both rail and steamboat. This home consists of Three new cottages for patients:

Eight old Cabins for patients,
One old Cabin used as a chapel.
One old Cabin used as a dispensary and surgery.
One new building used as a kitchen and dining room and in the basement employed as an amusement, or recreation hall.
There is a new cottage for the residence of the priest and the physician in attendance.

Besides these, the old plantation house is used for the residence of six sisters of charity (of the order of St. Vincent de Paul), and there are several out-bouildings used severally for power houses-for distributing water, hot and cold, and steam heat. The water supply is obtained from the Mississippi River and is filtered for household purposes.

The domestic and nursing departments are admirably administered by the Sisters in charge.

No measures against leprosy have been enacted since 1894 [1],

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1) „An Act to provide for the appointment of a Board of Control for the Leper Home, and to provide for the care and treatment of persons so afflicted with leprosy.

„Section 1. Be it enacted by the General Assembly of the State of Louisiana, That a Board of Control for the Leper Home, consisting of seven members, to be appointed by the Governor of the State, by and with the advice and consent of the Senate, whose duty it shall be to provide for the proper care, treatment and maintenance of all persons in the State of Louisiana, and for that purpose they shall be authorized to arrange with any responsible physician skilled in the care and treatment of such disease, for the care, treatment and maintenance of all such persons so afflicted; that said board shall have power to remove for cause said contracting physician, and annul his contract and enter into a new contract with any other physician in accordance with act No. 85 of the session of 1892.

„Sec. 2. Be it further enacted, etc. That the sum of five thousand dollars be and the same is hereby set apart for the purposes of repairing or constructing and improving such buildings as may be necessary for the purposes of said institute

as the laws then in force were as complete in scope as any in existence. In effect these provided for the report of all cases of leprosy and for their commitment by a local court to the State Asylum or Home for lepers —; also, the law established the present home and provided for a governing board to be appointed by the Governor of the State.

The Regulations are efficient as both the State and local boards of Health have been active in sending patients to the Home, and with the years from 1897 to 1904 at least ten cases have been sent by the court. Lepers are conveyed by the trains and under charge of the Sheriff of the Parish in which they are discovered and committed. Voluntary segregation is frequent, however. The leper simply applies to the Board of Control, and the patient is seen by a qualified expert (either Dr. Hopkins or Dr. Dyer usually), and on their official statement transportation is provided and the patient is admitted without further form or ceremony.

The Lepers at the Louisiana Home are occupied almost solely in eating, sleeping and taking care of themselves, some of them are musicians and there is a band of some seven or eight pieces. Most of those in good general health raise chickens and keep flower gardens around their cottages. At regular intervals there are concerts given among the inmates. The priest officiates at Mass regularly morning and evening and attendance is voluntary; it is usually large however.

Outside of the leper home there are a large number of lepers in Louisiana. Some of these, however, have been reported from different sections of the State, but the bulk of them have occurred in New Orleans. Many of them have been seen in the hospital clinics and for several years were not sent to the home as no provision for their proper medical treatment was made there. Again many cases report at the clinics but once and when they learn the diagnosis of their condition, are afraid to come again, even changing their homes to avoid detention.

Formerly New Orleans, Lafourche, & St. Martinsville were the only known centres of leprosy infection. Now almost every parish in the Southern half of Louisiana has present cases and here and there the Northern parishes have also. In 1897 the Parishes affected so far as known were:

„Sec. 3. Be it further enacted, etc. That the sum of ten thousand dollars per annum be and the same is hereby appropriated for the purpose aforesaid, and the Auditor is hereby authorized to warrant monthly for the said amounts on the order of the president of said board, countersigned by the secretary of the same.

„Sec. 4. Be it further enacted, etc. That as soon as practicable after the appointment of said board they shall meet and organize by electing a president and a secretary whose duties shall be prescribed by said board; all vacancies, whether by death, resignation or otherwise, on said board, shall be filled by the Governor.

„Sec. 5. Be it further enacted, etc. That the amount of appropriation provided for herein shall take effect and be available from and after the organization and appointment of said board, and after the election of said physician having been certified to by the Secretary of State.

„Sec. 6. Be it further enacted, etc. That all laws in conflict herewith be and the same are hereby repealed."

The Act was promulgated in August 1894.

Orleans (New Orleans)	Iberville
Jefferson	Feliciana (East)
St. Bernard	Acadia
Ascension	Lafayette
Assumption	Lafourche
Calcasieu	Plaquemine
Iberia	St. Martin
St. Charles	St. Mary
St. John the Baptist	St. Landry
St. Landry	Tangipahoa.
Livingston	

Since then several other parishes have been affected and it is not an overestimate to state that there are fully 300 or 400 lepers at large in Louisiana.

Maryland.

Dr. John S. Fulton, Secretary of the State Board of Health, under date of March 21st, writes:

„There is no known leper in Maryland. The last known case, M. Sansone, died about three years ago in the isolation ward of John's Hopkins Hospital where she had spent the last three years of her life“ . . . . . „The next earlier case recognised in Maryland was here in Baltimore in the early eighties.“

In 1898 Dr. Wm. Osler reported a German woman, aged 30, who had been born in the West Indies (Johns Hopk. Hosp. Reports. March 1898) probably identical with the case reported by him in 1897 (Maryland Med. Journ. XXXVII, No. 24.)

Dr. T. C. Gilchrist writes under date of April 19th, 1904 — stating that „only one case of leprosy has presented itself during the last 12 years. The case was seen about six years ago.“

No information regarding legislation either given or found.

Massachusetts.

The reply returned by Dr. Samuel W. Abbott, Sec. of the Massachusetts State Board of Health is to explicit to need courtailing or abstracting:

State Board of Health
State House,
Boston.
May 12th 1904.

„In reply to your circular of enquiry relative to leprosy, cases of this disease have been of very rare occurrence in this state, and consequently, there has been no necessity for special legislation in regard to it.

There are no colonies, nor asylums for the care of lepers, since the disease is not prevalent.

The following list comprises the reported cases of leprosy in Massachusetts during the past twenty-five years, so far as I can ascertain from published records and other information:

Cases of Leprosy reported in Massachusetts since 1880.

No.	Date of Report.	Sex.	Age.	Nativity.	Source of disease.
1.	Dec. 1882	Male	55	Massachusetts	Contracted in a long residence in Hawaii.
	This man arrived from Honolulu im Dec., 1882. Died, March, 1883.				
2.	— 1883	Male	35	Probably Cuban.	Unknown.
	Was brought to State Almshouse in 1883. An arrested case, loss of fingers, toes, &c., and other marks of leprosy. Ran away and never afterwards seen.				
3.	Apr. 12 1890	Female	—	Sweden	Sweden.
	Arrived at quarantine station, Boston, Apr. 28, 1890, and was sent home to Sweden in the following month.				
4.	Sept. 11. 1895	Male	—	Hawaii	Hawaii.
	Remained at quarantine 2 years or more and died.				
5.	Nov. 1900	Male	—	Negro, Baltimore	Unknown.
	Escaped May 8, 1903. Had been greatly improved by treatment with chaulmoogra oil.				
6.	— 1904	Male	—	Negro	Unknown.
	Mild case; waiter in restaurant; under observation.				
7.	— 1904	Male	—	Chinese	Unknown.
	Mild case; laundryman; under observation.				
8.	Apr. 1904	Male	38	Cape Verde Islands	Parents lepers.
	Came to United States 12 years ago; has shown signs of leprosy for five years, but disease was contracted before coming to United States; a farmer.				

March 22nd., 1904. Dr. James C. White writes:

„In this vicinity we see the occasional case of the disease in persons who have come from leprous communities: West Indies, South America, Hawaii, Japan, &c., and no others.“

March 22nd., 1904. Dr. Charles J. White writes „We have seen two anaesthetic cases at the Massachusetts General Hospital within a month, one a young woman, white, a native of the Danish West Indies, and the other, a young negro, coming from Antigua. In both cases the disease appeared and has remained on the lower legs at the end of some 18 to 24 months.“

March 23rd. 1904. Dr. J. T. Bowen writes „I have seen within the last six weeks two cases; one of the tubercular type, not very far advanced, in a boy who was born and had lived in Jamaica: another was a case of anesthetic leprosy in a girl who had lived in British Guiana. The girl lives in another state and the boy was sent back to Jamaica.“

Michigan.

March 22nd. 1904. Dr. Henry B. Baker, Secretary of State Board of Health writes:—

„There has never occurred, to my knowledge, a case of leprosy in this State."

Dr. Andrew P. Biddle, Editor of the Journal of the Michigan State Medical Society writes, Mar. 22nd, 1904:

„As far as my knowledge goes but one case has been seen in Detroit during the last 10 years, and that was an immigrant, a Syrian, I believe, who was stopped at this port, from Canada, by the U. S. Marine Hospital Surgeon and sent back to his native country."

Minnesota.

Dr. H. M. Bracken, Secretary of the Board of Health writes:

„My last report was given to the Am. Public Health Assoc. at the New Orleans meeting (Dec. 1903). No new cases have been reported since that time."

Legislation.

The Minnesota Board of Health memorialized the United States Congress regarding National Asylums on October 9th, 1900, when the necessity for such was strongly urged. Burnside Foster (Journal American Medical Association, Aug. 31, 1901) reports a case of leprosy in a young man 21 years old, who was born in Minnesota and who had never been out of the State. An older brother died of leprosy in 1898. Both of Norwegian parentage in which there was no history of leprosy.

Bracken reported a total of eleven cases of leprosy in Minnesota up to 1900 — all Norwegian. No isolation practised. In reviewing the Legislation and statistics (In Lepra, 1900) Bracken states that:—

Of Scandinavian lepers 5 of 11 are from Sweden. Family history of all immigrants from a country where leprosy prevails should be secured before they are allowed to embark for America. No member of a leprous family should be permitted to land on our shores.

Segregation should be insisted on in all cases. A federal home should be provided. Estimates a probable total of 160 Scandinavian lepers in the U. S.

Missouri.

Health authorities ignored communication.

March 24th 1904. Dr. W. A. Hardaway of St. Louis write
„During my long practice here I have met with a half dozen or
cases of leprosy, but I have kept no special record of them."

March 21th 1904. Dr. Joseph Grindon of St. Louis write
„The six or seven cases of leprosy I have seen in the last twenty od
years have all been in the practice of other men."

March, 1904. Dr. Martin F. Eugman, of St. Louis write
„Can only report having seen 4 cases of leprosy in my stay of seve
years in St. Louis; one from Mobile; one from Sweden; one Chinama
and one a resident of St. Louis. (The writer of this paper saw an

prescribed for a man, aged 40, in 1898, from St. Louis, with marked tubercular leprosy).

In 1897, Dusmenil reports one case (International Clinics, April 1897).

Montana.

Dr. Thos D. Tuttle, Secretary State Board of Health, writes (March 25th 1904) „We have never had a case in Montana“.

Nebraska.

Dr. S. R. Powne, Omaha, Secretary of the State Board of Health, writes (April 20th 1904): „There are no records in city or State of cases of leprosy.“ „I find that Dr. H. C. Snwiney some three years since (1901) saw a brother and sister, Scandinavians, from. Keya Poha County, near to Dakota Line, that were suffering from the anesthetic variety of the disease. He knows nothing of them now.“

New Hampshire.

Dr. Irving W. Watson, Secretary, State Board of Health says (March 22nd 1904) that „there is no case in the state and has not been for many years“.

New York.

The State Health Authorities ignored communications.

New York City.

The City Health authorities ignored communications.

Quite a number of men have seen leprosy in New York City.

General Observations.

Dr. Prince Morrow stated to me at Atlantic City, on June 8, 1904, that he had „altogether seen as many as 100 cases of leprosy in New York City“. One writer on leprosy has more than once stated that there were 100 cases of leprosy in New York City, now. The men interested in leprosy in New York are for the most part entirely cognizant with the attitude of the Health authorities who take no notice of the disease, and who do not believe in its contagiousness nor in its danger to the community. While the Associated Press was sending all over the world the report of the results of the 1897 Berlin Lepra Conference, New York City was letting its lepers go their own way because two or three men from the Academy of Medicine had concurred in the opinion that the disease was not contagious in New York.

This attitude probably explains the meagre information derived from the city of New York. Among the individuals solicited were members of the American Dermatological Association and others usually interested in kindred subjects: of these not a few were personal friends and acquaintances of the writers.

Now remark the information derived:

Dr. Herman G. Klotz (March 21st 1904): „I have had no personal experience with lepers.“

Dr. Geo T. Elliot (March 21st 1904): „One sees too little of

it here in New York to be in a position to give more than theoretical opinions in regard to the questions you desire."

Dr. George Frederick Laidlaw refers to one case now under treatment.

Dr. H. H. Whitehouse stated that he had seen one case the latter part of May, an Italian, 45 years old.

Dr. F. Dillingham reported a case before the N. Y. Post graduate Society early in 1904: male, aged 58, born in America trophic type.

In 1898, Dr. C. L. Gibson reported a case before the N. Y. Surgical Society, a mulatto, 25 years old, trophic type. In 1899 Dr. H. D. Chapin (N. Y Medical Record, Jany 7) reports four lepers 1) Wm. B. Coe. Male. Aged 19. trophic Native of Danish West Indies. Admitted to Riverside hospital in April 1895; 2) Ling. Male. Chinaman, aged 28. Admitted May 14, 1897. Tubercular type; 3) Philip D. Coe. Native of admitted Jany 21, 1897. Mixed; 4) Fred F. German. 40 years old. Baker. Lived in Brazil several years. Tubercular type.

The rest of observers of leprosy in New York City are silent.

Brooklyn.

Dr. J. M. Winfield under date of June 3rd gives a very satisfactory statement of his observations in Brooklyn which we quote in full.

„During the past twelve years I have had under my care or observation nine undoubted and one probable cases of leprosy; of these four were tubercular and five anaesthetic.

„Three of the tubercular cases were natives of Key West, and of English descent; relatives, father, son and uncle. The first case was the son aged fourteen, he developed the disease while living in Key West, came to Brooklyn and was put under my care. I had him segregated at the Brooklyn Contagious Disease Hospital, where he died after three years. The uncle had lived in Brooklyn for many years, he undoubtedly developed the disease here; was ill for about two years, the correct diagnosis of his disease not being made until shortly before his death which occurred at his own home. The Father of the first case moved to Brooklyn after his son was placed in the Contagious Disease Hospital. After living here he showed unmistakable signs of tubercular leprosy and died one year later. He was not removed from his home.

„The fourth case of tubercular leprosy occurred in a tremp a native of Louisiana or Georgia. He spent the greater part of his life in tramps lodging houses and died at the age of fifty in my service at Kings County Hospital. Where he had contracted the disease or how long he had it I was unable to learn.

„The diagnosis of these for cases were confirmed by the microscope.

Anaesthetic Cases. two occurred in Chinamen, age unknown, one died with all the attendant mutilations, at Kings County Hospital.

„The other was admitted at Kings County Hospital where he re-

mained for one month, as the case was a mild one he was allowed to disappear. (Entre nous this occurred after Brooklyn was annexed to New York.)

„I have under may care at present an anaestetic leper, a negro native of St. Kits aged twenty-six; he showed the first symptoms fourteen years ago, after he had been a resident of Brooklyn for two years. He is greatly mutilated and has been nursed by his mother, whom I think is beginning to show symptoms of the mixed variety.

„Another native of St. Vincent, colored, a resident of Brooklyn for the past eight years, aged aboud twenty, had the disease when he came here, and it is slowly progressing.

„The last case is a white boy aged sixteen native of Barbadoes. Showed the first symptoms of the disease four years after becoming a resident of Brooklyn. Disease slowly progressing.

„While New York is considered one of the leper centers, it is not so strictly speaking, for all of the cases, so far as I can learn, are either natives of, of long residents in notoriously leprous countries.

„Although some of the cases developed the disease before they came to New York, many have shown their first symptoms after living here a number of years.

The belief of some that leprosy is comparatively harmless in a temperate climate is to my mind dangerous. For all leprologists know that the disease is contagious (inoculative) and it is my opinion that a leper, no matter where he comes from, where he develops the disease, or where he lives, is a menace to the community in which he lives, and when a case is once discovered it should be placed under proper surveillance."

Buffalo.

„I never saw a case of leprosy in this section of the country and cannot find that any of my fellow practitioners have ever done so, neither do our local records contain reports of any cases." Dr. Grover W. Wende. March 26/04.

North Carolina.

„Not a single case in the State." (Unsigned statement from the Board of Health.)

Ohio.

Secretary Dr. O. O. Probst gives me no information regarding legislation but refers to Dr. Mc Dougall's 2 cases of leprosy.

Dr. O. Ravogli, of Cincinnati says „In 23 years no case of leprosy has been seen by me."

Dr. J. G. McDougall reports two cases with photographs, in 1895, from New Lexington, Ohio.

In 1904 (Cincinnati Lancet Clinic, February 13, 1904) Dr. M. L. Heidingsfeld reports a case of „Sporadic tubercular Leprosy."

Oregon.

Since 1890, only Chinese immigrants who have been promptly deported.

No cases in Oregon at present. (Dr. Woods Hutchinson, State Health Office). Oregon has a deportation law and Health officers are required to examine passengers of incoming vessels for leprosy.

Pennsylvania.

State authorities made no acknowledgement of communications.

The only direct information was from the pen of Dr. Joy F. Schamberg of Philadelphia, who states:

„During the past 15 years the city of Philadelphia has had under its care 9 cases of leprosy. The nationality of these was as follows: 2 Chinese; 1 Japanese; 2 Brazilians; 1 Swede; 1 Russian (from Island of Oesel in Baltic Sea); 1 American and 1 Hawaian. All of these patients were males save two.

„These patients were confined at the Municipal Hospital for Infections Diseases in a cottage set aside for the purpose. Four died at the hospital; two were sent to Brazil, one to Chester, Benna., whence he had come, one escaped and is now in the Louisiana Colony (Martin Parry), and one is still at the hospital. The last named is a Hawaian whom I saw but recently and sent to the hospital. He came to Philadelphia on a sail boat a year and a half ago and has since been working in this city.

„He has a mixed type of the disease, but declares that the eruption upon the skin has only appeared within two months, a statement which might well be true as to the nodules present.

„I append the scanty date at our command concerning the American woman, for the circumstances are of interest. (Notes made on admission to the Municipal Hospital in 1892.)

„Mrs. Peterman, age 67, was born and has always lived in Philadelphia. Family history negative. Says she was in contact as long as forty or fifty years ago with a person who was said to have elephantiasis. She says a red spot appeared on her leg about 40 years ago and this never entirely disappeared. She insists that the disease did not become prominent until a year ago (1891). A pigmented anaesthetic patch then appeared upon the back. Microscopic examination revealed the presence in the skin of bacilli.

„After several years residence in the hospital tubercles developed upon the face and hands. She died in 1892 at the age of 77. I made an autopsy upon her and excised lesions for microscopic study. Bacilli were found in abundance in the tubercles and less numerously in a chloasma-like patch on the face and in the spleen.

„This case is of interest inasmuch as this woman was never outside of Philadelphia and its suburbs. On close interrogation concerning contact with a person alleged to have had elephantiasis, I was told that members of her household had visited a sailor friend who had elephantiasis, but the patient (whose memory was clouded) was

not sure she had ever seen him. This whole history is very vague, but it is the only clue that could be obtained.

„I may also refer to a patient who was brought to my office in the summer of 1902; this was a well-to-do gentleman from a town in Arkansas, who was passing through Philadelphia on his return from Atlantic City. He had a well pronounced tubercular leprosy which had been diagnosed as Addison's disease owing to the bronzing of the skin. He had no knowledge of ever having come in contact with a leper."

1903. Dr. J. Shoemaker reports a case (Proc. Phila. County M. S., Jan. 31, 1903).

Dr. Van Hailingen writes (March 28, 1904): „I have not seen a case of leprosy for some years."

Rhode Island.

Dr. Gardner T. Swartz, Secretary of the State Board of Health, sends a full report of the only case on record in the state.

Report of a case of leprosy which presented itself in the city of Providence, R. I., in the year 1902.

„In July 1902 there was admitted into the Rhode Island Hospital in the city of Providence, State of Rhode Island, a Mr. A. Swift. He was admitted on account of having ulcers on both feet and on parts of the big toe. In addition to these ulcers he presents a mottled bronzing of the chest and abdomen which looks like vitiligo. There is no loss of sensation on either of the white areas or on the bronzed portions of the skin. The face presents a thickened, hypertropic enlargement of the skin. The lower lip is thick and protruding; the patient states, however, that this is peculiar to his mother's side of the family. His speech is thick but he assures us that this has always been the case. There has been considerable loss of hair upon the chin and upper lip; the loss of hair upon the scalp is not more than is usually seen but appears to be universal. At the time of his admission there was considerable oedema of both lower legs and on the fore-arms and hands. After three or four days in bed this oedema entirely subsided. There is anaesthesia and loss of sensation of pain upon most of the area below the knees and involving the lower portion of the fore-arms and of the hands. Sensation of heat and cold are lost in certain areas; tactile sense, however, remains. When a pin is plunged into the flesh and muscle to quite a depth he realizes no pain but merely has the feeling that something has touched him.

„From these symptoms and from the history of his having lived in Brazil five years ago, and as this condition has been very slowly advancing, the clinical diagnosis of leprosy was made by the attending physicians at the hospital. In addition to these findings the microscopical examination of the secretions of the nose reveals the presence of large numbers of bacilli which answers to the description of the lepra bacilli in morphological appearance, and from that of staining. A piece of tissue taken from the skin of the anaesthetic portion of the

leg also reveals these same bacilli found in clumps in leucocyte cells, and some bacilli being scattered through the epithelial tissue.“

[Since located patient somewhere in Pennsylvania.]

South Carolina.

No acknowledgement of communications by Health authorities. A number of cases of local leprosy (W. H. Geddings, Medical Record, Oct. 3, 1891) were reported between 1847 and 1891 but none since.

Texas.

Dr. George R. Tabor, State Health Office of Texas writes (March 23, 1904). „So far as I know there is only one case in Texas, located in Liberty County, seven miles from the town of Liberty, the leper being an Acadian Woman who has had the disease for several years, supposed to have contracted it in Louisiana.“

In 1889 (Trans. Texas State Med. Assoc.) Dr. Geo. Dock reported two cases from Galveston.

1 H. B. aged 48. German. Tubercular.

2 G. P. aged 48. Alsatian. — Both lived in Galveston over 20 years.

In 1901 (Trans, Texas State Med. Assoc.) Dr. M. Duggan of Eagle Pass, reported a case in a woman aged 36, German American. Tubercular type.

This same case was subsequently seen by the writer and was once reported by Dr. R. S. Woodson, U. S. A., from Fort Clark, Texas.

In a letter referring to a case of leprosy, Dr. Edward Randall of Galveston, mentioned the frequent occurrence of the disease in that city. At my request he gives as clearly as possible the detail of these cases, which are here noted.

1. Fritz D . . . ., 36 years old, born in Galveston of German parents. Disease recent. Tubercular type. 1904.
2. Young woman of 26. Tubercular. 1903. Bacilli present.
3. D — Young woman, fifteen years old, mixed case. Bacilli found in nose secretions.
4. — D — aged 34 mother died of same disease.
5. XX Janitor at Medical School.
6. — Bergman, a mattress maker, had the disease 15 years; well known case in Galveston. Bacilli were found.
7. — P — Man. Watchman at R. R. Station. Bacilli were found.
8. E. M. A young man of good family — died in New York in 1892.

Besides these cases of Dr. Randall's, the writer has seen two others in Galveston, one a young woman of 30 a dressmaker, with well marked tubercular leprosy. The other a negro (mulatto), with trophic type, who lives in the West end of Galveston.

Under date of June 15th 1904 Dr. Woodson writes from Fort

Clark that he has another case in a Mexican. Texas has no legislation regarding leprosy.

Vermont.

Dr. Charles S. Caverly, writes as President of the Board of Health „I do not know that there has ever been a case of leprosy in Vermont".

Virginia.

Dr. P. A. Irvine, secy of the Board of Health „There is not a case to my knowledge, in Virginia".

Washington.

The Health officials report one case, a Chinaman, who disappeared. (Dr. D. C. Newman. Sec.)

Wisconsin.

Dr. U. O. B. Wingate, Sec. of the State Board of Health, writes that there used to be some 30 cases in Wisconsin; three only remain; the others have died. No instance of the disease contracted. Some cases are under care of County authorities; others own property and live at home, isolated, by themselves, and are cared for by their friends.

U. S. Army.

The first case of leprosy in the Army is reported by Surgeon Harry L. Gilchrist (Report of the Surgeon of the Army, 1903) in a subject who had been 10 years in the army service, 8 weeks passed in Cuba.

General Conclusions.

So far as the information for the United States is concerned we must express the opinion that the bulk of it is not worth much except to express the indifference to conditions on the part of most Boards of Health and the expressed lack of interest in many who have answered interrogations, not to remark at length on those who did not answer at all.

It must at once appear an impossible task to gather any reliable information on short notice. (The notice to the writer was received the end of January and material had to be collected by June Ist.) To prepare a proper paper on the subject in hand must needs take more than a few months, and the writer excuses rather than apologises for the insufficiency of the completed task.

Countries in „North America" other than the United States.

Mexico.

The only official notice of circulars and personal communication received by the writer indicated that the necessary work incident to obtaining the desired information would take more time than the Minister of Public Health could give to such a cause!

I am most assuredly indebted to Dr. R. H. L. Bibb, of Saltillo,

Mexico, for information outside of the City of Mexico. His letter is graphic: —

„I regret exceedingly my inability to contribute anything of interest or any data based on other than personal observation, concerning leprosy in this country . . . . there being no asylums, no hospitals, no reports, no colonies, no institutions, nothing whatever to which one may look for information."

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to ignore the possibility of the father's contagion while the son was under treatment, for it is known that the father paid no heed to the warnings given him by the physician to prevent his infection and both father and son occupied the same bed.

The Saad family consists of four members, two of whom are contaminated by leprosy, as we have just stated, and two others, another boy and girl, who, apparently at least, are no infected by the disease. The healthy son keeps a shop (No. 137 St. Lawrence St.) and is assisted by his brother who is cured. Since August last, the family lives in the story above the shop. The elder Saad does nothing since he has been ill and is supported by his sons.

The elder Saad, though not cured, manifests no contagious symptoms for the present. This opinion of the attending physician (Dr. Valin) is corroborated by Dr. Shepherd who was also consulted by the patient and finally by Dr. A. C. Smith, superintendent of the leper Lazaretto of Tracadie, N. B., and an expert in this matter who was requested by your Executive Committee to give his opinion.

The municipal health authority of Montreal request to be told—as the result of your deliberations—what measures you wish them to take under present circumstances. I therefore beg to submit to your consider action the following draft of instructions:

I. A thorough desinfection shall be made of the apartments occupied as lodgings by the Saad family. This purification of their home is necessary for the protection of the well members of the family, it having probably been contaminated by the sick, as all the precautions recommended by the attending physician have not been followed.

Such disinfection will be preferably done by steam sterilization, for all that can be thus treated (bedding, clothing, carpets, &c.) by sprinkling pieces of furniture with bichloride of mercury in solution and by washing the walls and floors with the same.

II. Saad junior, being considered as cured by his physician, will be submitted to no restrictions so long as nothing occurs to set his recovery in doubt.

III. Saad the elder may continue to live with his family, provided he follows to the letter the orders that will be given to him by the municipal health authority.

IV. Saad the elder and also Saad junior shall be submitted to a medical sanitary surveillance. They shall report themselves to the Medical Officer of health of Montreal: the son once a month, the father twice a month. The medical examination which will then be made of them shall, besides search for the tegumentary lesions, include the examination of the nose and throat. If the examination of the nose or throat reveals any suspicious symptoms, a bacteriological examination of the exsudation will have to be made.

V. At the least indication of skin ulcerations or of coryza, the patient must receive immediate medical attendance, antiseptic dressing of broken surfaces, antiseptic douches for the nose and throat, expectorations to be received in spittoons filled with water and subsequently disinfected.

The Medical Officer of health shall decide as to what can be permitted in reference to the patient going out.

VI. As the smallness of the lodgings occupied by the Saad family does not allow of all its members having a separate room, the occupation of the same room by the father and his *cured* son may be tolerated, but so long only as the father will continue to be free from contagious symptoms. However, each of them shall have his own bed, which is not the case at present, and moreover, each shall have his separate toilet articles. At the least indication of a contagious symptom on

Saad the elder, the room shall be vacated by his son (who, if cured, can reinfect himself), or better, the patient shall be isolated in a hospital.

VII. Clothing and bedding used by the father should always be washed separately from that used by the rest of the family. In any case, from the moment that the patient shows contagious symptoms, this separate washing shall be obligatory, unless the clothing be previously disinfected either by immersion in disinfectant solutions or be boiled. The City is requested to supply the disinfectants to the family. The discarded surgical dressings shall immediately be burnt.

VIII. The attention of well members of the family will be called to the dangers they would expose themselves by neglecting the precautions which the sanitary authority prescribes to them. They should be informed how the disease is transmitted.

IX. The sanitary conditions of the dwelling shall be supervised by a sanitary inspector who will frequently inspect it. The advice given by the inspector will include recommendations as to personal hygiene of the inmates; cleanliness of the body, frequent baths especially, being one of the best measures of protection against spreading or taking the disease.

X. If at any time the leper presents contagious symptoms, the supervision of the special measures to be followed should be entrusted to a certified trained nurse, who could by a daily visit to his home readily see what is done or is not done. The „Victorian order of Nurses“ seems to be the best fitted for this kind of *ambulatory service*, which is its speciality. Il from the present the surveillance of the dwelling were entrusted to the Victorian Order of Nurses, we could almost guarantee a successful issue for this outbreak of leprosy, as well understood measures of hygiene would not fail to be put in practice by the family, and this would prevent all danger of infection.

XI. The Medical Officer of health shall supplement the above instructions should circumstances arise which have not been foreseen.

XII. The Board of Health of the Province reserves the right to modify the present instructions, should it deem it opportune at any time.

Respectfully submitted,

Elzéar Pelletier, Secretary.

P. S. As we are exposed to fresh importations especially through emigrants from Southern China, a country where leprosy prevails, the Board of Health might, in my opinion, avail itself of the present opportunity to insist upon the corporation of the city of Montreal having periodical inspections made of the Chinese centres that are becoming more and more numerous in it. E. P.

(The Conclusions of this report were approved of by the Board, at its meeting of the 14th March 1903.)

Ontario.

Dr. John T. Shepherd of Montreal writes:— „We only see imported lepers here, Chinese and West Indian. There is leprosy in Cape Breton and also at Trocadie, New Brunswick, where there is a leper Hospital.“

Ottawa.

Dr. F. Montizambert, Director General of Public Health of Ottawa has kindly taken the trouble to supply all available information regarding leprosy in New Brunswick and British Columbia.

New Brunswick and British Columbia.

Source of information:— Dr. A. C. Smith of Trocadie, New Brunswick gives a most interesting and explicit acount of the leprosy conditions in these two provinces.

Leprosy (Lepra tuberosa and Lepra maculoanaesthetica) in the Province of New Brunswick, Canada.

Leprosy first appeared in New Brunswick in 1815. From the first official reports we learn that the first known case was that of a French woman, Ursule Benoit — née Landry, whose paternal grand-father came from St. Malo, a leprous district in Normandy, France. Her father, Anselm Landry, was born in this Province (N. B.). Her mother, Mary Brideau, was born in the Province Quebec, and was twelve years old when she came to this Province.

One improbable account of the origin of leprosy in M. B. is that two leprous sailors came to Caraquet, distant twenty miles from Tra-cadie, and that Ursule Landry washed their clothes and afterwards became leprous. Ursule's mother denied this story.

It has been asserted that two Norwegian sailors found their way to Quebec City and there took passage in „La Florida" which navi-gated the Baie des Chaleurs in the early part of the last century, Capitain Michael Landry in command. These men left the vessel at Caraquet and walked to Tracadie. They were in an advanced stage of leprosy. While in Tracadie they remained a few days with Joseph Benoit, husband of the above mentioned Ursule. Ursule afterwards became a leper, in 1815, and died of her disease in 1828. Her hus-band, Joseph Benoit, also became affected and died, leprous, in 1834. Ursule's two sisters subsequently became diseased and died lepers, as did several of their children. When Ursule died Francis Soniers was one of those who carried her coffin to the grave. In doing so the coffin, from the bottom of which matter was seen oozing, abraded the skin of his shoulder. The matter saturated his shirt over the site of the abrasion. He was infected and in one year was a leper. Some time previous to his death he slept at Savoie's in Neguac, about twenty miles south of Tracadie. Marie Savoie washed the clothes of the bed on which Sonier had slept, became leprous and died. Since then several lepers have been brought to the lazaretto from Neguac — one quite recently.

It is not shown that any of Ursule's forefathers were leprous. There is no doubt that the disease started with Ursule, appearing in others who were not her blood relations. Ursule probably infects her husband Joseph Benoit, also her sisters Isabella and Francoise, and, as stated above, Francis Sonier. Francis Sonier infects his sister Edith, Marie Savoi of Neguac, and several others. Edith infects other Soniers, several Robichauds, and a Cyril Austin. Cyril Austin infects a Brideau; and very many Brideaus afterwards became inmates of the lazaretto. And so leprosy spread rapidly through contagion. As a result two hundred and ninety lepers have already been admitted to our lazarettoes since its inception.

It was not until 1844 that Government measures were taken to arrest the spread of the disease in this Province. A lazaretto was built on Sheldrake Island, on the Miramichi River, and in the following year it had eighteen inmates. Two others had escaped. In 1849 the lepers were removed to a new lazaretto in Tracadie. In 1851 thirty seven lepers had been gathered in. In 1854 Honble. Dr. Gordon was the medical attendant. In 1861 Dr. James Nicholson was appointed. He died in 1865 and Dr. A. C. Smith was immediately appointed to the position. When Dr. Nicholson took charge he found the lazaretto under the management of a Board of Health to whom had been given despotic power. Lepers were hunted like wild beasts, dragged from their hiding places, handcuffed and thrown into what was a cheerless prison surrounded by a wall twelve feet high with a row of long iron spikes on the top to prevent escape. Dr. Nicholson threw down this prison wall and a better day began to dawn on the wretched inmates. Notwithstanding the existence of the lazaretto segregation was not complete. At one time there were twelve lepers in the institution and eighteen others running at large.

The lazaretto is now under the gentle sway of Sisters of Charity who act as nurses and attend to the preparation of food and clothing. It is now a Lepers Home; and in no part of the world are lepers so tenderly cared for by a paternal Government as here in Tracadie.

For the last twelve years segregation has been complete. The physician-in-charge keeps a record of families tainted with leprosy and visits them from time to time. There is no law in Canada compelling lepers to enter the lazaretto. The old Board of Health ceased to exist many years ago. The physician in charge advises the immediate friends and relatives of any leper he may discover; warns employers of labour, and the unfortunate leper soon finds himself ostracised and willingly enters the Home. As the result of very careful segregation leprosy is rapidly dying out here. From Tracadie, so long its hidingplace, no lepers have been admitted to the Institution for many years. Recruits come from outlying districts where Tracadie lepers had at one time removed, creating new foci of the disease. Many years ago a girl, resident in a French district over thirty miles from Tracadie, came here on a visit and lived for a part of the winter with a French family in which there was a leper girl. The girl returned home in the spring. She infected her family. The disease spread with much rapidity over the district; nearly every family had one or several lepers. Only of late have we succeeded in stamping out the malady.

Our lepers are French. Some English persons with no possible taint of leprosy are on our records as having contracted the disease here through contagion-some through working with lepers in lumber camps in the winter months.

The lazaretto is supported by an annual grant from the Federal Government. Municipalities, parishes, Provincial or Local Boards of Health, etc. etc. never interfere in the management of the institution or with our mode of segregation. The lazaretto is the only one of the kind in Canada, with the exception of a very small one for Chinese lepers in British Columbia. There have been some cases of leprosy

in Cape Breton, Province of Nova Scotia, among the immediate descendants of Scotch emigrants from the Hebrides, Scotland, arriving here in and about 1810, and among others infected by them. Some years ago all known cases were segregated at their own homes until they died, and the disease no longer prevails. Bacteriological examinations aided in differentiating from other diseases closely resembling leprosy.

There are twenty six beds for lepers in the Tracadie lazaretto-but few now occupied. There has been a steady and rapid decrease in the number of our lepers for years. To careful segregation, aided by the improved condition of our people, I attribute the decrease.

Our lepers have no employment, but take exercise by out-door life during a portion of each day; also in sailing in the harbour, shooting wild fowl, etc. etc. They are cheerful and seem contented. A good and varied diet, and warm clothing are provided.

Our lepers are never admitted to general hospitals, lunatic asylums, infirmaries, or prisons.

I know of no sporadic cases in Canada.

Removals of lepers from distant points are made by schooner, sail boat, horse, etc. etc. In no instance were Railway trains made use of for advanced cases. In a few cases a special fourth class car has been employed but the travelling public were not admitted.

Our climate is healthy. The winters are cold but bracing; the summers are cool and pleasant. The country is undulating. well supplied with pure water, free from malaria, and is well adapted for farming. In former years the people were uncleanly in their habits. Their diet then consisted almost entirely of eel-soup and of fish imperfectly cured, and tainted.

A. C. Smith. April 18st, 1904.

Tracadie Lazaretto,
Tracadie, Province, N. B., Canada.

British Columbia.

There are now only two lepers on D'Arcy Island, B. C. Both cases are Chinese (males) aged 20 and 30 respectively. The one of 20 has tubercular leprosy and is still fairly vigorous; the other has the nervous form of the disease and is getting quite feeble. The one has been four years on the Island, the other eight years. Both cases were discovered in British Columbia. The younger one came from Victoria and the other from Vancouver. The health authorities of Victoria have the care of the lepers but Vancouver or any other city or municipality has to pay for the maintenance of any patients sent from such city or municipality.

Nova Scotia.

Dr. A. P. Reid of Reidvale, Middleton, Nova Scotia, and Secretary of the Provincial Board of Health, writes under date of March 24 1904:— „We have nothing in this Province.“

British West Indies.

The only information regarding leprosy conditions since 1897 in the B. W. I. has been through Dr. T. J. Tonkin and Dr. W. D. Neish; the former through personal correspondence, the latter through official governmental report.

Both, however, give data regarding Jamaica only.

In the „Report on the Lepers' Home of Jamaica" for the period from April 1. to December 31. 1898, Dr. Neish gives some interesting points to date:

1. The death rate of Leprosy has largely decreased in ratio to the population.
2. Leprosy is on the decline in Jamaica. [1])
3. Only one case of acquired leprosy related, viz: a cook after 16 years service in the Home.
4. Leper Law since 1896.
5. Average rate for 20 years, 13.5 per cent.
6. Marked improvement noted under treatment with perchloride of mercury injections after Crocker's method. Sixty-six patients were so treated and these were remarked — Sensation returned; sprinkling of tubercles; healing of ulcerations; improvement in general tone of patients.

In a joint paper on „Leprosy in Jamaica" (Bristol Medico-chirurgical Journ., March 1904) Drs. Neish and Tonkin, there is a further review of conditions at the Spanish-town, Jamaica, Leper Home. Here the data are brought down to 1903; showing the relative decrease in admissions, considering that since 1896 a Leper law has been in force.

Years	Admissions
1898—99	20
1899—00	27
1900—01	19
1901—02	9
1902—03	—

At present in the Home there are about 110 cases and about 150 more at large. In all about 4 lepers to 10 000 of population. Of the 110 cases 66 are males and 44 females. One person reputed to be pure white, five coolies, and the rest colored and black, mostly black. Anaesthetic form predominates. Intercurrent diseases most frequently are of conjunctive or pulmonary and intestinal, sometimes nephritis. Ten years for the anaesthetic and 7 for the tuberculated are the periods over which fatal leprous disease usually extends.

It is interesting to note that both writers are firm believers in

1) Table of admissions to Jamaica Leper Home for 20 years: —

Year	Leprosy	Year	Leprosy	Year	Leprosy	Year	Leprosy
1879	21	1884	30	1889	26	1894	21
1880	31	1885	36	1890	35	1895	32
1881	39	1886	27	1891	36	1896	38
1882	34	1887	33	1892	15	1897	40
1883	35	1888	35	1893	27	1898	19

316 admitted first 10 years — 237 admitted second 10 years.

the arrest, if not the curability of leprosy under careful diet and persistent treatment.

Danish West Indies.

The extensive work of Dr. Edouard Ehlers of Copenhagen, recently concluded in the March 1904, Number of „Lepra“ [1]) makes it unnecessary to add anything more than a reference to it in the highest terms of compliment and praise.

At Dr. Ehlers Suggestion, legislation is contemplated.

Iceland.

Dr. Edouard Ehlers has also reviewed the lepra conditions in Iceland and much of his work is summarized in a paper of Dr. Judson Daland read before the Philadelphia Medicine Society in 1903 (Proc. Phila. Co. Med. Soc. vol. XXIV, No. 1; new series, vol. V. page 9).

The population of Iceland is about 70 000. Lepers estimated at 200. Leprosy has been in Iceland since 1651. A law forbidding intermarriage of lepers caused a reduction of the disease in earlier times. In 1894—95 there were 158 lepers, more males than females and the tubercular type predominant. In 1898 the first leper asylum was to be opened.

Legislation in Iceland (1902) directs that:

1. Records of all cases shall be kept by district physicians.
2. Physicians must instruct leprous families regarding contagion.
3. When general directions regarding utensils, family associations &c. are not obeyed, the prefect is authorised to compel isolation in the Leper Hospital.

Cuba.

Dr. E. Robelin (Revista de Medicina Tropical, tom III, No. 3) relates that up to the time of the American intervention he had examined as many as 300 lepers. He estimates the prevalence of the disease as about 1500 in Cuba. He distributes 1160 specifically as follows:

Province of Pinar del Rio	275	(Estimate)
„ „ Puerto Principe	250	„
„ „ Santa Clara	120	„
„ „ Cardenas	40	„
„ „ Santiago de Cuba	175	„
In and about Havana	300	„
	1160	

Dr. Corlett writing in 1898 (in the Cleveland Medical Gazette, vol. 13. p. 395) states that he saw lepers on the Streets of Havana and mild cases in the shops.

In Cuba, however, much has been done to isolate, study, and treat leprosy.

In 1901 before the Pan-American Congress held at Havana, Dr. Manuel F. Alfonso presented a paper on „Leprosy in Cuba“, which briefly gives an idea of the prevalence of the disease. The first hos-

1) La lèpre aux antilles danoises, &c. Lepra, vol. IV., fasc. 3, 1904.

pital for the disease was established in 1681 by Pedro Alegré on a farm called „Los Pontones“. Similar institutions were established at Santa Clara and Puerto Principe. According to Alfonso leprosy has not spread much and has a „marked tendency to disappear“. The present hospital of San Lazaro rose on the site of the institution founded by Alegré.

Alfonso gives the following statistics:

Number of patients admitted to San Lazaro Hospital, from the year 1830 to 1900 both inclusive: —

White: —	Men	Spaniards	52
		Cubans	267
		Canaries	75
		Other nations	19
	Women	Spaniards	4
		Cubans	138
		Canaries	9
		Other nations	4
		Total	568

Colored:	Men	Africans	150
		Cubans	101
		Mulatoes	21
	Women	Africans	68
		Cubans	70
		Mulatoes	19
		Total	429

Chinese, mens, 199.

Total by races: —

White	568
Negroes	389
Chinese	199
Mulatoes	40
Grand Total	1196

„The above figures have been obtained from the records of the hospital which were started in 1830. Of the 429 colored male patients in the hospital, six were married and one of them was married twice. Of the women, seven negroes were married, and a mulato woman was married 4 times; of this race 4 boys and 4 girls have been born in the hospital; 4 men and 4 women have left the institution as cured cases. Besides these 4 men who had been committed to the hospital during the Spanish rule, as a punishment (!) also left the institution.

„Of the white race in the hospital, 7 men were married and 5 women; 4 children were born, 3 male and 1 female. It also appears that 3 men were committed to the hospital not for being lepers but for vagrancy, and 1. man as a political prisoner. Six men and 1 woman have been discharged as cured.

„The majority of the cases have been from 25 to 70 years old.

„During the time that the writer has been in charge of the institution 8 patients have been discharged on account of not suffering from leprosy, but some other cutaneous disease.“

The writer of the present paper made a personal visit to the Havana „San Lazaro“ in 1902 (September) and through the courtesy of Dr. Alfonso saw the institution thoroughly. It is situated in the very best part of Havana, in full view of the Prado and not far from the north side of the city, overlooking the Gulf of Mexico. The

building is of brick a stone and cement, severely plain, and three stories high. The Wards are arranged in high ceiled rooms, each with a running balcony, overlooking a rectangular Court yard. The centre of the space occupied by the hospital is filled by a chapel, with its entrance open to the street. The entrance to the hospital itself is up one flight and leads through the offices of the administration — supplies etc. to the north side of the building (which faces East) where the Wards begin. The wards are whitewashed, the beds are plain, but there is every evidence of a well conducted institution. At the time of my visit there were 114 cases. Almost all of these were of late trophic types, the so-called „effete" leprosy of Zambaco-Pache. I recall only three or four true tubercular types. Paralyses, deformities of the extremities, facial atrophy and general senile aspects were common. Results in treatment were negative, as might have been expected with such degenerative cases.

Modern therapy was practised and especially the perchloride injections and Red Mangrove bark „Mangle" as they called it there. Dr. Alfonso held chaulmoogra oil as the best remedy in his hands and while he had no „cures" to report he said that some amelioration had been obtained in recent cases.

Altogether the „San Lazaro" was creditable both to its immediate direction and to the Cuban Government.

In 1902 report of leprosy cases were not compulsory and only in indigent cases were the sanitary authorities called upon to act. The domestic care of the patients and the hospital are in the hands of the Sisters of Charity of the order of St. Vincent de Paul.

Frankreich und Kolonien.

Bericht

von

M. E. Jeanselme in Paris.

Première partie.

La lèpre en France.

La France ne peut être classée parmi les pays à lèpre, car le nombre des lépreux qui vivent sur son territoire, eu égard au chiffre de la population, est infime.

Tous les cas qu'on y observe peuvent entrer dans l'une des catégories suivantes:

I. Lèpre exotique importée en France.

Nombre de missionaires ou religieuses, de colons, de marins ou de soldats, de fonctionnaires contractent la lèpre dans les possessions françaises, puis rentrent dans la mère-patrie soit lorsque la terrible maladie s'est déjà démasquée soit pendant le cours de sa longue incubation. Des étrangers originaires de contrées où la lèpre est endémique, dès les premiers indices révélateurs du mal, accourent en France dans l'espoir d'y trouver la guérison.

Grâce à la multiplicité et à la rapidité des transports qui abrègent les distances, l'afflux de ces lépreux vers la France va toujours grandissant. A Paris, circulent environ 160 à 200 lépreux. A l'hôpital Saint-Louis, il y en a toujours une douzaine environ. En moins de dix ans, j'ai pu y étudier près de quatre vingt cas provenant tous de pays notoirement lépreux. Ce sont les Etats de l'Amérique latine (Cuba, Saint-Domingue, la Guadeloupe, la Martinique, le Mexique, la Colombie, le Venezuela, les Guyanes et le Brésil) qui fournissent le plus gros contingent. Les autres sources d'importation sont, par ordre de fréquence decroissante: la Nouvelle-Calédonie et Taïti, la Réunion, le Sénégal, l'Inde anglaise, la presqu' île indo-chinoise et Java.

Dans nos grands centres maritimes, comme dans la capitale, les cas de provenance exotique, sans être communs, ne sont point rares. Une enquête rapide et nécessairement incomplète, dit M. Pitres[1]),

1) Pitres, La lèpre en Gironde à notre époque. Soc. de Méd. et de Chirurgie de Bordeaux. 19. Déc. 1903.

prouve qu'en moins de vingt ans il a été observé trente cas de lèpre à Bordeaux. Et il ne s'agit là que des cas avérés et non pas de ces formes frustes et ambiguës qui donnent prise au doute. En 1898, M. Perrin comptait à Marseille onze cas de lèpre importés soit d'Italie, soit des Colonies[1].

Ces agglomérations artificielles de lépreux ne constituent pas de foyers à proprement parler, car jusqu' à présent elles ne paraissent, pas avoir contribué à propager la lèpre en France. Il y a pourtant quelques exceptions à cette règle comme on va le voir.

II. Lèpre de provenance exotique, transmise à des sujets n'ayant jamais quitté la France.

Les cas ressortissant à cette catégorie sont d'une extrême rareté. Mais certains sont très démonstratifs, tel celui d'une française, dont M. Lande a rapporté l'histoire, qui sans avoir jamais quitté le sol natal fut contaminée par un enfant lépreux qu'elle soignait depuis plusieurs années; tel encore celui de M. Perrin ayant trait à une femme qui, sans sortir de France, prit la lèpre au contact de son mari devenu lépreux en Indo-Chine[2].

III. Survivance de la lèpre autochtone.

A l'époque de la Renaissance, la lèpre était encore très répandue en Bretagne, dans les provinces du sud-ouest et sur le littoral méditerranéen. La description si vivante et si précise que nous a laissé Ambroise Paré, montre bien que la maladie n'était pas alors en voie d'extinction. Cependant, au XVIIe siècle, la lèpre rétrocède rapidement et le 24 août 1693, un arrêté royal transforme les maladreries, Maisons-Dieu, etc .... en établissements généraux hospitaliers.

La lèpre, ainsi rayée de la liste des maladies officielles, continua à végéter obscurément et, à l'heure actuelle, il existe encore, en France, quelques vestiges de cette maladie.

La Bretagne et les départements qui bordent la Méditerrannée sont les seules régions où elle a garde quelque importance.

A vrai dire, il n'existe pas, sur la côte bretonne, de foyers véritables. Cà et là sont disséminés quelques cas solitaires et en fort petit nombre.

Sur la côte ligurienne, il existe encore plusieurs petits foyers. En 1807 et 1808, Valentin affirme que la lèpre est endémique à Vitrolles de temps immémorial. Il avait observé 6 cas, dont 3 affectaient la forme „squameuse et écailleuse“ c'est-à-dire trophoneurotique et les 3 autres la forme tuberculeuse. L'un de ces derniers a été reproduit par Alibert dans son Atlas des maladies de la peau.

Valentin fit une troisième enquête en 1820, et constata que ce foyer était éteint; un seul lépreux, guéri dit-on, survivait depuis douze ans. Fodéré et Valentin ont aussi observé quelques cas d'éléphantiasis, autrement dit de lèpre tuberculeuse, dans les communes qui

1) Perrin, Onze cas de lèpre observés à Marseille. Marseille médical. 1898. p. 612.

2) Lande, Mém. et Bull. de la Soc. de Méd. et de Chirurgie de Bordeaux. 13. Nov. 1885. p. 453.

environnent l'étang de Berre. Aujourd'hui ce petit foyer est à peu près éteint et il ne subsiste plus dans cette région que 4 lépreux d'après le médecin des épidémies. Enfin, à l'époque où Valentin observait, il y avait quelques lépreux dans la Vallée de l'Huveaune. M. Boinet a fait à plusieurs reprises et en dernier lieu, en 1897, sur ma demande, une enquête sérieuse sur la lèpre dans toute cette région. Il a recherché les descendants des lépreux dont Valentin avait donné les noms. Il a retrouvé les vestiges d'une douzaine de ces familles et il a examiné avec soin ces individus de souche lépreuse. „Aucun n'est actuellement entaché de la lèpre."

Il y a une quarantaine d'années, avant l'annexion du Comté de Nice à la France, le gouvernement Sarde ému des progrès menaçants que la lèpre faisait dans la région de la Riviera ouvrit à San Remo une léproserie qui fut inaugurée pas Charles-Albert en 1856.

On y réunit, de gré ou de force, une centaine de lépreux provenant surtout de Nice, de Menton, d'Eze, de la Turbie, de Roquebrune et de ses environs. Cette mesure n'a pas définitivement chassé la lèpre de cette région. En 1888, M. M. Chantemesse et Moriez ont fait connaître quatre petites épidémies locales qui avaient causé une vingtaine de victimes. Les villages contaminés étaient Laghet, Tourette, Eze et Saint-Laurent d'Eze. Il existe aussi des foyers à Peille, à la Trinité-Victor et à Contes. J'ai vu en 1896, à l'hôpital St. Louis, une lépreuse originaire de cette localité; sa mère avait succombé à la lèpre [1]).

Tous les petits villages que je viens de mentionner sont situés, soit dans la vallée du Paillon (qui se jette dans la Mediterranée, à Nice où il y a quelques lépreux), soit dans son voisinage immédiat. Il faut également remarquer que toutes ces bourgades sont éloignées des grandes voies de communication et qu'elles sont situées à une certaine altitude. (Contes à 260 m, Eze à 400 m, la Turbie à 486 m, Peille à 630 m.) Telles sont probablement les raisons pour lesquelles ces petits foyers n'ont pas gagné les stations hivernales qui semblent être complètement indemnes [2]).

Il résulte de la dernière enquète conduite par M. M. Boinet et Ehlers [3]) que la lèpre est en pleine décroissance dans les Alpes-Maritimes où elle n'est plus representée que par quelques cas isolés. Quand aux anciens foyers situés dans les départements du Var et des Bouches-du-Rhône, ils sont à peu près éteints.

Donc il n'est pas nécessaire de prendre des mesures défensives contre cette lèpre autochtone en voie de disparition spontanée. Mais l'apport incessant de lèpre exotique puisée aux sources les plus viru-

1) L'enquête officielle faite en 1894—1895 par le médecin des épidémies sur la lèpre dans l'arrondissement de Nice mentionne 21 cas, chiffre un peu inférieur à la réalité car les renseignements faisaient défaut pour les communes très-suspectes d'Eze et de la Turbie qui n'ont pas de médecin.

2) Jeanselme, E., Rapport sur la lèpre en France et dans ses Colonies. Lepra-Conf. 1897.

3) Boinet et Ehlers, Un vieux foyer de lèpre dans les Alpes-Maritimes. Lepra. Vol. III. fasc. 1. p. 17.

lentes ne laisse pas d'être inquiétant. Contre elle, rien n'a été entrepris. La lèpre, en France, ne figure pas sur la liste des maladies dont la déclaration est obligatoire. Lié par le secret professionnel, le médecin ne paut donc intervenir utilement en faveur de la société. Son rôle de protection social se réduit à donner au lépreux des conseils pour éviter la contamination de son entourage; ces avis qui ne sont pas impératifs sont rarement écoutés.

Suivons la piste d'un de ces lépreux de la classe aisée depuis le moment où il débarque dans un port français; que va-t'il faire? D'abord il gagnera la capitale ou quelque autre grand centre dans l'espoir d'y obtenir la guérison; il se logera dans un hôtel ou une maison meublée, prendra des domestipues à son service, circulera par la ville en employant tous les moyens publics de transport. L'été, il ira dans une ville d'éau ou une station balnéaire. Bref, sous le couvert de son incognito, il se mêlera, sans aucune entrave à la population saine, semant partout sur son passage des germes infectieux. J'ai même connu deux jeunes lépreux qui faisaient leurs études dans un grand lycée voisin de Paris.

La prudence conseille de ne pas s'endormir dans une quiétude parfaite. Mais que faire? Trois ordres de moyens préventifs ont été proposés: la surveillance sanitaire des lépreux; — l'interdiction faite aux lépreux d'entrer en France; — la création d'un sanatorium.

M. Thibierge, à la Conférence internationale de Berlin, a préconisé la première mesure: La visite sanitaire obligatoire pour tous les sujets, provenant des pays contaminés, est impraticable, dit-il; cependant, celle-ci pourrait être appliquée à certaines catégories de suspects, tels que les militaires et les marins ayant fait campagne en pays lépreux, les fonctionnaires du service colonial et pénitentiaire. Les sujets reconnus lépreux seraient signalés par leurs administrations respectives aux autorités sanitaires du lieu de la résidence, qui connaîtraient ainsi les cas importés, assureraient leur surveillance, leur faciliteraient la pratique de la désinfection et, au besoin, l'hospitalisation [1]).

M. Hallopeau tient pour la seconde mesure. Il demande: 1. que l'entrée des lépreux par les ports maritimes soit interdite; 2. que dans chaque port de mer un médecin spécial examine à ce point de vue les passagers; 3. que les médecins des navires soient tenus de faire la déclaration de la lèpre existant à bord [2]).

En ce qui concerne les lépreux provenant de nos colonies, la tâche serait assez facile, car la plupart des coloniaux français sont des fonctionnaires et, comme tels, soumis à une visite sanitaire avant d'être rapatriés. Mais il reste à savoir s'il est expédient d'user d'une telle rigueur envers des compatriotes qui ont contracté la lèpre au service de la France. Vis-à-vis des lépreux étrangers, l'interdiction serait illusoire. Elle ne deviendrait éfficace que le jour où la France conclurait, avec les Etats de l'Amérique latine et les autres pays à lèpre, une Convention semblable à celle que les gouvernements allemand, persan,

1) Thibierge, La prophylaxie de la lèpre dans les pays où elle n'est pas endémique. Paris 1897 et Lepra-Conf. Tome II. p. 180.

2) Hallopeau, Lepra-Conf. Tome II. p. 185.

roumain, russe et turc ont signés récemment. La dite convention décide que dans l'avenir les puissances intéressées ne délivreront pas de passeport pour l' étranger aux lépreux, ni même de carte de légitimation[1]).

Le projet de fonder un sanatorium pour lépreux a été mis en avant par Dom Santon qui avait choisi pour emplacement la commune de Ronceux, située à quelques kilomètres de la ville de Neufchâteau (Vosges). Le Comité consultatif d'hygiène publique de France, sur la proposition de M. Netter, son rapporteur, émis l'avis „que la création, en France, par l'initiative privée, d'un sanatorium destiné à recevoir des lépreux rendrait de très grands services, et ne constituerait pour le voisinaque aucun danger". Dans la région, qui est tout à fait indemne de lèpre, l'émotion fut grande. Les Conseils municipaux de Ronceux et de Neufchâteau ayant fait entendre de vives protestations, le ministre de l'Interieur consulta l'Académie de Médecine. Celle-ci nomma une Commission dont M. E. Besnier fut le rapporteur. „**Placé en lieu opportun,** dit le savant léprologue, c'est-à-dire le plus-près possible des points où subsistent des foyers lépreux, solidement réglémenté par l'autorité sanitaire, et soumis par elle à la surveillance intérieure et extérieure indispensable, un sanatorium privé pour lépreux peut avoir une utilité réelle, et remplirait, en outre, un but humanitaire qu'on ne saurait trop hautement apprécier".[2]) L'Académie adopta les conclusions formulées par sa Commission. Le **lieu opportun** pour fonder un sanatorium, ce serait la côte de Bretagne ou mieux encore le littoral méditerranéen, mais les nombreuses stations balnéaires et hivernales qui s'échelonnent sur ces rivages ne toléreraient à aucun prix le voisinage d'un asile de lépreux.

Je crois, pour ma part, que le trois solutions proposées peuvent être prises en considération. Empêcher l'afflux des lépreux en France, surveiller ceux qui y résident et leur offrir un asile secourable sont des mesures salutaires et nullement contradictoires. Mais l'application de ces principes ne va pas sans de grandes difficultés, car elle lésera nécessairement des droits acquis et des intérèts fort respectable.

Deuxième partie.

La lèpre dans les Colonies Françaises.

La lèpre a été „de tout temps l'objet des préoccupations constantes des administrations locales, à en juger du moins par les nombreuses dispositions prises dans nos vieilles colonies pour isoler les malades". Ainsi s'exprime M. l'Inspecteur général du Service de Santé des Colonies et rien n'est plus vrai. Mais ces décisions, prises sous le coup de la terreur, n'ont jamais été sincèrement exécutées. „Nos colonies de la Guyane, des Antilles et de la Réunion, poursuit le même auteur, possèdent des léproseries, mais elles ne renferment que des malheureux qui, n'ayant aucun moyen d'existence, trouvent là un refuge pour abriter

1) Depuis 1894, il est interdit de débarquer des lépreux dans les ports des Etats-Unis d'Amérique.

2) Besnier, E., Bull. de l'Acad. de Médecine. 21. Mai 1901.

leur misère; „Et plus loin: Des décrets prescrivant les mesures propres à enrayer la maladie ont été prises pour la Guyane et la Nouvelle-Calédonie, mais ils sont restés lettre-morte".[1])

Des prescriptions insuffisantes, mal adaptées aux races qu'elles doivent régir, des règlements faits avec le secret désir qu'ils ne soient jamais appliqués; parfois des mesures de rigueur soudaine pour satisfaire l'opinion publique momentanément terrorisée par les progrès de la lèpre, puis, quand le danger semble écarté, retour à l'apathie coutumière, telle est jusqu'ici la conduite incohérente de nos Colonies vis-à-vis d'un fléau toujours grandissant. On conçoit que cette absence de continuité dans l'effort n'ait pas permis d'organiser solidement la lutte contre la lèpre dans nos possession d'outre-mer.

Exception doit être faite pour la jeune colonie de Madagascar, où le Général Galliéni, secondé par le Corps de Santé des Troupes coloniales, a organisé, sans tâtonnements, l'assistance médicale et entrepris résolument d'enrayer la marche de la lèpre.

Chapitre 1. **Afrique du Nord** (Algérie-Tunisie-Maroc).

En 1897. M. M. Gémy et Raynaud ont signalé l'immigration en Algérie de lépreux espagnols provenant, pour la plupart, de la région de Valence et d'Alicante. Ceux-ci ont crée dans un quartier d'Alger appelé la Cautère, un véritable foyer qui s'étend progressivement. Aux 24 cas qu'ils avaient recueillis en 1897, M. M. Gémy et Raynaud peuvent aujourdhui en ajouter 21 inédits. Parmi ces derniers, cinq ont trait à des individus de souche espagnole, mais nés en Algérie, et 6 à des immigrants qui ne sont devenus lépreux que 7, 20 et même 30 ans après avoir quitté l'Espagne. Il semble donc évident que la majorité de ces malades ont contracté le lèpre en Algérie au contact de leurs compatriotes.

Cet afflux de lépreux espagnols fait courir à Colonie le danger d'autant plus réel que ces immigrants exercent des professions qui les mettent en contact plus ou moins intime avec la population européenne.

Les hommes pour la plupart se placent comme ouvriers ou comme domestiques chez l'habitant et, quant aux femmes, elles allaitent les enfants des colons, car toutes les nourrices d'Algérie viennent de la province d'Alicante.

M. M. Gémy et Raynaud, après la Conférence de Berlin, ont obtenu qui la déclaration de la lèpre devint obligatoire en Algérie et qu'on isolât les malades atteints de plaies ouvertes. Le Gouvernement décida en outre qui les navires espagnols serraient soumis à une visite médicale et, grâce à cette mesure, un certain nombre de lépreux furent écartés. Malheureusement ces prescriptions sont difficilement applicables. Des lépreux avérés circulent par la ville vendant des pâtisseries et des arachides. Raynaud connaît deux malades qui

1) Instructions concernant les mesures à prendre contre les maladies endémiques, épidémiques et contagieuses, rédigées par l'Inspecteur général du Service de Santé des Colonies. Annexe de 92 pages aux Ann. d'Hyg. et de Méd. Coloniales. 1903.

font le commerce du lait, soit à Alger, soit dans sa banlieue. D'après certains indices, il est à supposer que les ouvriers maltais, italiens et siciliens peuvent introduire la lèpre dans la province de Constantine et en Tunisie, mais de ce côté le péril est moins pressant.

Abstraction faite des cas d'importation étrangère, il existe des exemples de lèpre autochtone parmi les Arabes, mais surtout parmi les Kabyles. M. Legrain a vu des lépreux originaires de toutes les communes de l'arrondissement de Bougie. Cette lèpre kabyle ne forme pas de foyers cohérents; elle ne paraît pas en voie d'extension, mais il faut la surveiller pour agir en cas de retour offensif[1]).

De temps immémorial, la lèpre est connue au **Maroc**. Dans le Roudh el Kartaś (histoire des souverains du Maghreb), on lit que la ville de Fez possédait près de la porte el Koukha un „bourg des lépreux.“ En 1222, quand on reconstruisit la ville, les lépreux allèrent s'établir un peu plus loin, dans des grottes. Vingt ans plus tard, sous prétexte „qu'ils se baignaient, lavaient leurs vêtements, vaisselle et autres objets dans la rivière et compromettaient et la santé des autres musulmans“, ou les relégua dans les cavernes de Bordj el Koukob.

Actuellement il n'y a plus de léproserie à Fez, mais tout un faubourg de Marrakesh, près de la porte Doukhala est destiné aux lépreux.

Près de Mazagran, à une heure environ de la ville, existait encore, il y a quelques années, un village de 200 lépreux, désigné dous le nom de Douar el Medjdàma. Un beau jour, le caprice du Sultan fit disperser les habitants de ce village. Beaucoup se réfugièrent au „hara“ de Marrakesh. Les terrains furent livrés aux nouveaux possesseurs sans que les maisons aient été détruites.

Le hara de Marrakesh est composé de huttes en chaume et en terre battue entourées d'un mur à demi écroulé. Marcet (Le Maroc, 1885) dit que les gens du hara sont presque tous sains. Il n'a vu, parmi ces malheureux, que deux cas de lèpre, quelques eczémas et quelques psoriasis.

Au Maroc, où règne le bon plaisir, la séquestration arbitraire d'individus sains, faussement déclarés lépreux, n'est pas rare, car il n'y a pas d'examen médical. Le ladre porte un costume spécial, il vit des dons de sa famille, des revenus des mosquées, des aumônes des passants dont il attire l'attention, dans certaines régions, avec une sonnette. Defense lui est fait d'aller en ville, mais il ne tient pas compte de cette interdiction, et de vrais lépreux parcourent les rues de Tanger[2]).

Chapitre 2. — Côte occidentale de l'Afrique.

Au Sénégal la lèpre est endémique. Mais dans cette vieille colonie, qui fait partie de notre domaine d'outre-mer depuis le XVIIe siècle, la fusion des races s'est éffectuée, et la population qui envoie

1) Gémy et Raynaud, Etude sur la Lèpre en Algérie etc. Monographie de 103 pages avec planches et cartes. Alger 1897. – Raynaud, La lèpre dans l'Afrique du Nord. Le Caducée, 11 avril 1903. — Raynaud, La lèpre dans le Nord de l'Afrique. L'invasion lépreuse en Algérie. Journ. de Mal. cutanées et syphilitiques, Août 1903. p. 566. — Legrain, La lèpre en Kabylie. Rev. médicale de l'Afrique du Nord. Janvier 1903.

2) Raynand, L., Journ. des Mal. cutanées et syphilitiques. janvier 1901. p. 3.

un député au Parlement s'opposerait à l'application de toute mesure portant atteinte à la liberté individuelle. La lèpre est très-fréquente dans le cercle de Thiès (Sénégal). Elle serait d'importation récente et gagne graduellement de l'est vers de l'ouest. Le sentiment de la famille et de la liberté individuelle est assez émoussé pour que les indigènes acceptent l'isolement. Les Sérères, pleuplades qui ne se mélangent pas aux autres tribus sont indemnes de lèpre.

Dans la Guinée française, sur la côte d'Ivoiré, au Dahomey, au Congo, les lépreux errent en liberté. Dans certaines régions, ils sont fétiches et relégués comme tels dans des cases éloignées des villages. Les gens de la tribu sont chargés de leur apporter, chaque jour, leur nourriture[1]). Par crainte de la contagion, il est interdit à ces lépreux de quitter leur demeure sous quelque prétexte que ce soit.

Dans le Liptako, une des plus grandes provinces de la bouche du Niger, la lèpre que les Foulbé appellent Barsou, n'est pas rare. La forme anesthésique est prédominante[2]).

Dans le Chari, territoire situé en plein centre de l'Afrique entre les 5° et le 15° de latitude Nord et le 10° et 18° de longitude Est, la lèpre n'est pas une maladie commune[3]).

Dans la région de l'Afrique centrale francaise: dépression du Tchad, du Congo, Oubanghi etc., la lèpre serait rare d'après l'administrateur Gaboriaud (Communication orale).

Chapître 3. — **La lutte contre la lèpre à Madagascar**[4]). Tafel I.

La lèpre est partout présente à Madagascar. Mais l'endémie n'a pas en tout lieu la même intensité. Les provinces de l'Emyrne et le Betsiléo sont trés éprouvés. La côte Nord-Ouest est aussi ravagée par la lèpre, surtout dans les régions riches et commerçantes, et particulièrement aux points où le trafic des esclaves africains, généralement pratiqué par des Arabes, était le plus actif (baie d'Ampasindava, baie de Baly, villages du cap Saint-André). En ces régions, les cas sont nombreux; ils s'observent dans toutes les races, mais surtout chez les Maquois, esclaves d'origine africaine. Bien que tous les types cliniques de la lèpre soient représentés, c'est la forme nerveuse mutilante qui est la plus répandue. Les lépreux pourchassés se groupent en villages, généralement situés dans des ilôts comme Sakatia, près de Nossi-Bé[5]).

Les Sakalaves, qui occupent la plus grande partie du versant occidental de Madagascar, se sont mieux défendus contre l'extension de la lèpre. Ils la tiennent pour très-contagieuse. Dès les premiers

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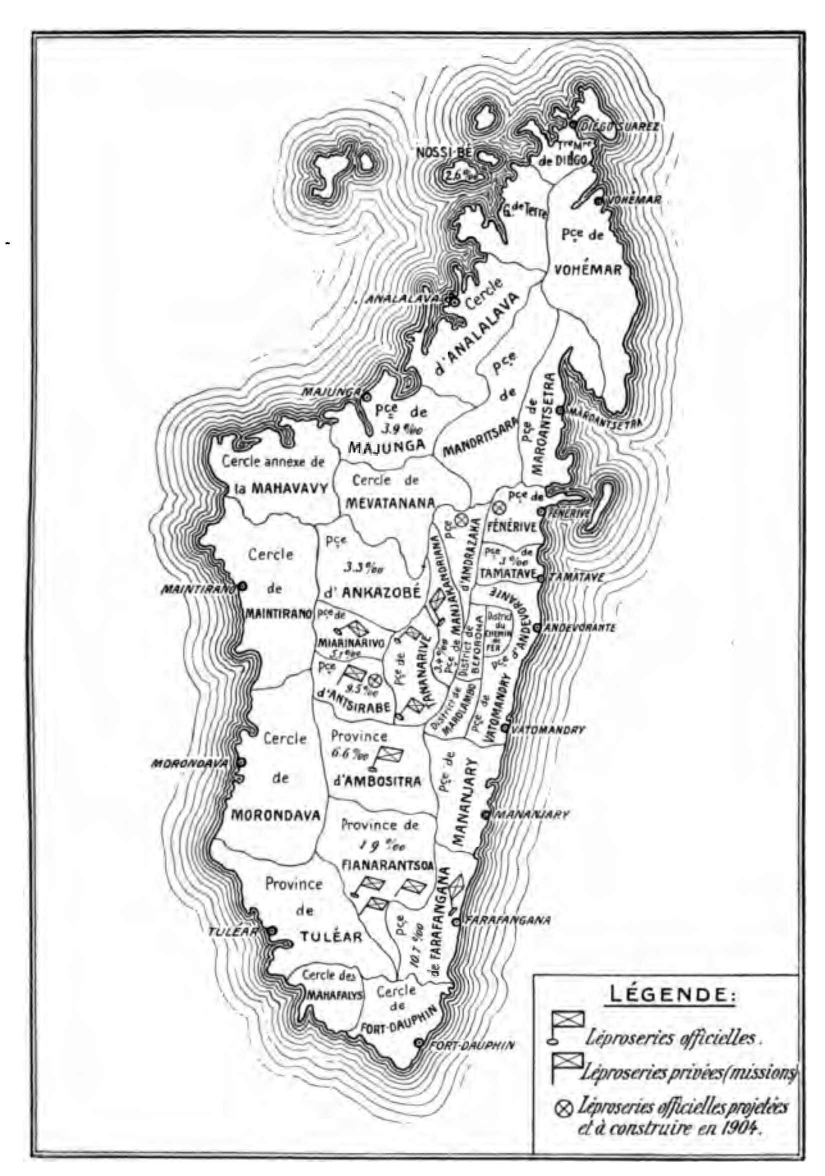
1) Kermorgant, La lèpre dans les Colonies françaises au cours de l'année 1901. Ann. d'Hyg. et de Méd. Coloniales. 31. mars 1903.

2) Vallet, Notes médicales sur le poste de Dori, région du Liptako. Ann. d'Hyg. et de Méd. Coloniales. 1901. p. 98.

3) Morel, La lèpre dans la colonie du Chari (Afrique). Ann. d'Hyg. et de Méd. Coloniales. 1903. p. 260.

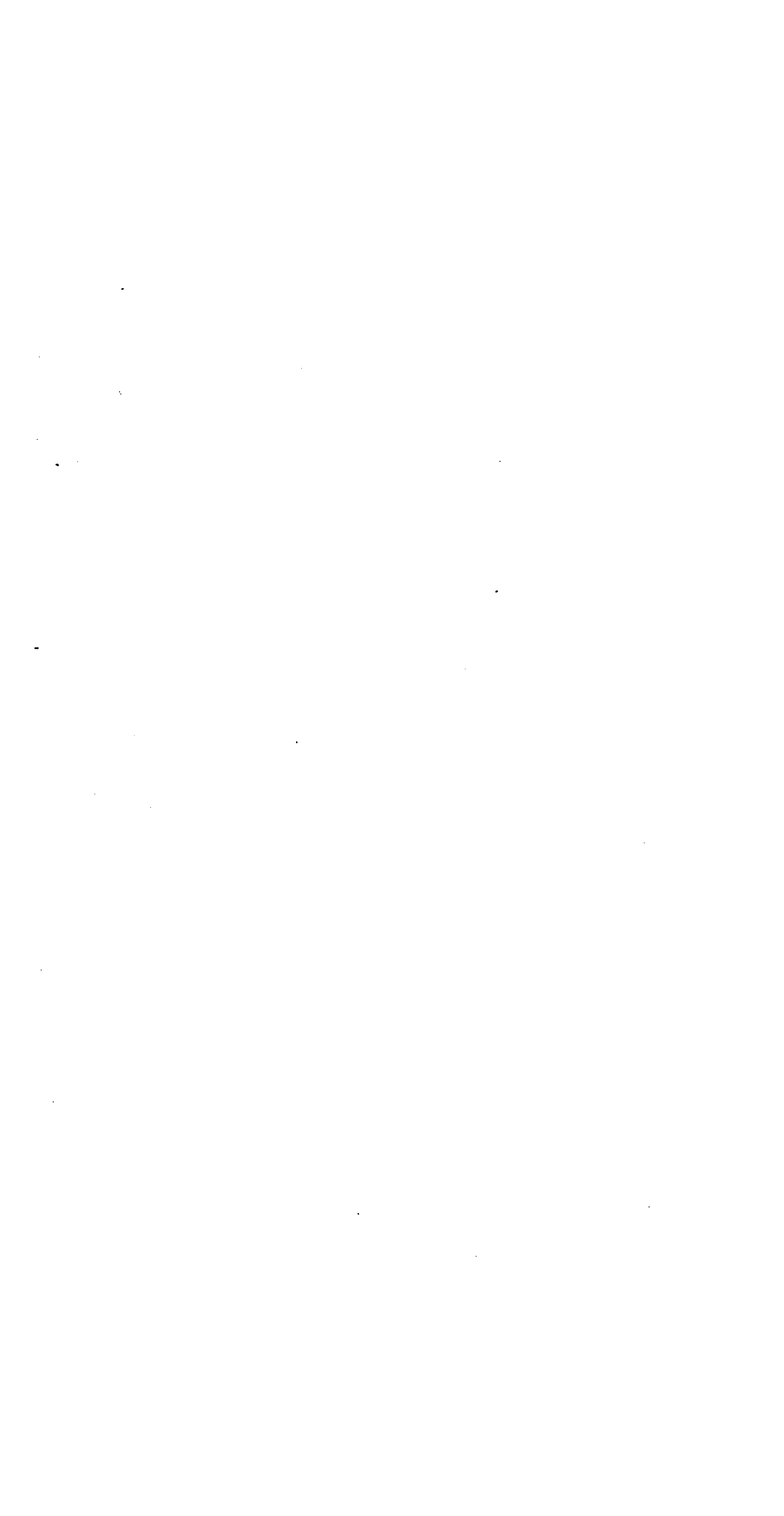
4) Je tiens à remercier M. le Général Galliéni, gouverneur général de Madagascar, et M. l'Inspecteur Clarac, Directeur du Service de Santé de la Colonie, de l'empressement qu'ils ont mis à me fournir tous les documents nécessaires à la rédaction de ce chapître.

5) Joly, La lèpre à Madagascar. Arch. de Méd. navale. juin 1901, p. 459.



Répartition de la Lèpre à Madagascar.

(Les chiffres indiquent la proportion des lépreux pour 1000 habitants.)



symptômes, le lépreux est expulsé de son village et parqué dans une case spéciale où il vit séparé de sa femme et de ses enfants. La famille continue à assurer sa subsistance. Elle dépose des aliments devant la case d'isolement, mais sans y pénetrer. Le lépreux mort, son corps est enfoui dans une fosse remplie de boue. Le deuil n'est pas porté et les réjouissances qui accompagnent ordinairement les funérailles n'ont pas lieu. Le mort est redouté à l'égal du vivant. Tous les assistants couvrent le cadavre de pierres pour chasser son esprit et l'empêcher de faire de nouvelles victimes dans le village[1]).

Le tableau ci-joint, qui m'a été fourni par M. le Général Galliéni, gouverneur de Madagascar, donne un aperçu de la répartition de la lèpre dans cette colonie.

I. Plateau Central.

Provinces		Population	Nombre approximatif des lépreux	Pourcentage des lépreux par rapport à la population saine
Tananarive	Ville	55 000 h.	1200	3,7
	Province	271 482 h.		
Ankazobé		71 315 h.	250	3,3
Manjakandriana		177 660 h.	600	3,4
Miarinarivo		58 766 h.	300	5,1
Antsirabé		105 087 h.	1000	9,5
Ambositra		151 000 h.	1000	6,6
Fianarantsoa		357 888 h.	700	1,9
Totaux:		1 248 198 h.	5050	

II. Provinces côtières[2]).

Provinces		Population	Nombre approximatif des lépreux	Pourcentage des lépreux par rapport à la population saine
Côte Ouest.	Majunga	33 252 h.	130	3.9
	Analalava	36 920 h.	120	3,2
	Grande Terre	32 000 h.	100	3,1
	Nossi-Bé	30 000 h.	80	2,6
Côte Est.	Farafangana	280 000 h.	3000	10,7
Totaux:		412 172 h.	3430	

De ce relevé, qui est certainement très-inférieur à la vérité, il résulte que le nombre des lépreux, officiellement reconnus à Madagascar, dépasse le chiffre de 8 000, sur une population évaluée approximativement à 1 600 000 habitants.

Le gouvernement malgache ému des progrès du fléau avait prescrit des mesures d'isolement. Le Code des 305 articles, promulgué le

1) Lasnet, Notes d'éthnologie et de médecine sur les Sakalaves du Nord-Ouest. Ann. d'Hyg. et de Méd. coloniales. 1899. p. 492.

2) Si l'on excepte la province de Farafangana, le recensement des lépreux de la région côtière est très incomplet. Ces chiffres peuvent être majorés de 50%.

29 mars 1881 par la reine Ranavalomanjaka, contient la disposition suivante:

„Les lépreux doivent être conduits aux lieux qui leur sont assignés. Si des personnes tolèrent le voisinage de lépreux, sans en avertir l'autorité pour que leur expulsion soit ordonnée, elles seront punies d'une amende d'un boeuf et d'une piastre. Si elles ne peuvent payer l'amende, elles seront mises en prison à raison d'un sikajy[1]) par jour jusqu' à concurrence du montant de cette amende" (art. 67).

Mais, sous le règne de Ranavalona III, ces sages prescriptions étaient tombées en désuétude. Les lépreux étaient tolérés sur les voies publiques, à proximité des villages. Echelonnés par petits groupes, quelquefois par familles, cachant sous leur lamba ramené jusqu'aux yeux les ravages de la hideuse maladie, ils chantaient aux passants leur mélodie plaintive: „Que Dieu vous récompense et que votre offrande devienne l'escalier qui vous permette de monter au ciel!"[2])

Les missions norvégiennes et anglaises avaient fondé plusieurs léproseries bien avant la conquête. Mais c'était des oeuvres de charité et non pas de prophylaxie. Le but que se proposaient les missionnaires étaient de secourir les malades indigents et de leur procurer un peu de bien-être. De la contagion ils n'avaient cure. Dans ces établissements, le lépreux entrait et sortait à son gré. Dans quelques-uns même, la cohabitation des personnes saines et malades était tolérée.

On peut donc dire que tout restait à faire au moment où le général Galliéni fut nommé gouverneur de Madagascar. Convaincu du rôle capital que joue l'hygiène et la prophylaxie dans l'oeuvre de colonisation en favorisant l'accroissement de l'élément indigène, son premier soin fut d'organiser l'Assistance médicale. La lèpre qui compromet l'avenir de la race ne fut pas oubliée et, dès les premiers jours, la lutte fut résolument engagée contre ce fléau. Aujourd'hui, sur les 8480 lépreux officiellement reconnus, 3 299 sont internés dans des léproseries nombreuses et bien aménagées qui appartiennent au gouvernement ou qui sont subventionnées et surveillées par lui.

Les tableaux ci-joints indiquent la répartition des léproseries et le nombre des malades hospitalisés (page 230):

Plusieurs des léproseries du plateau central sont très bien aménagées et méritent une description.

Léproserie de Ambohidratrimo.[3]) Tafel II.

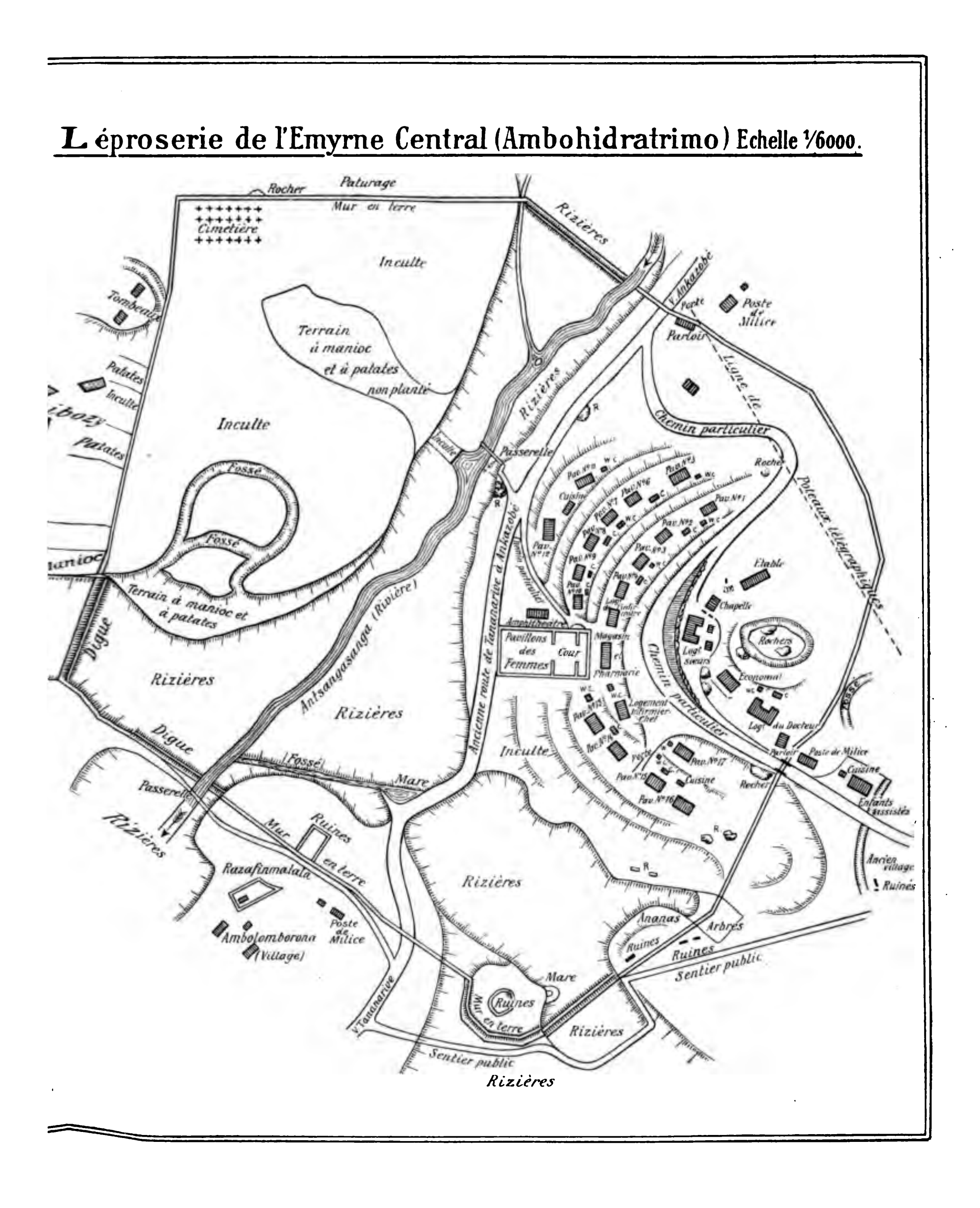
Cet établissement est situé à flanc de côteau, dans un endroit isolé, distant de 15 kilomètres environ de Tananarive dont il reçoit les lépreux. Il est entouré d'un mur continu, en pisé, haut de deux mètres.

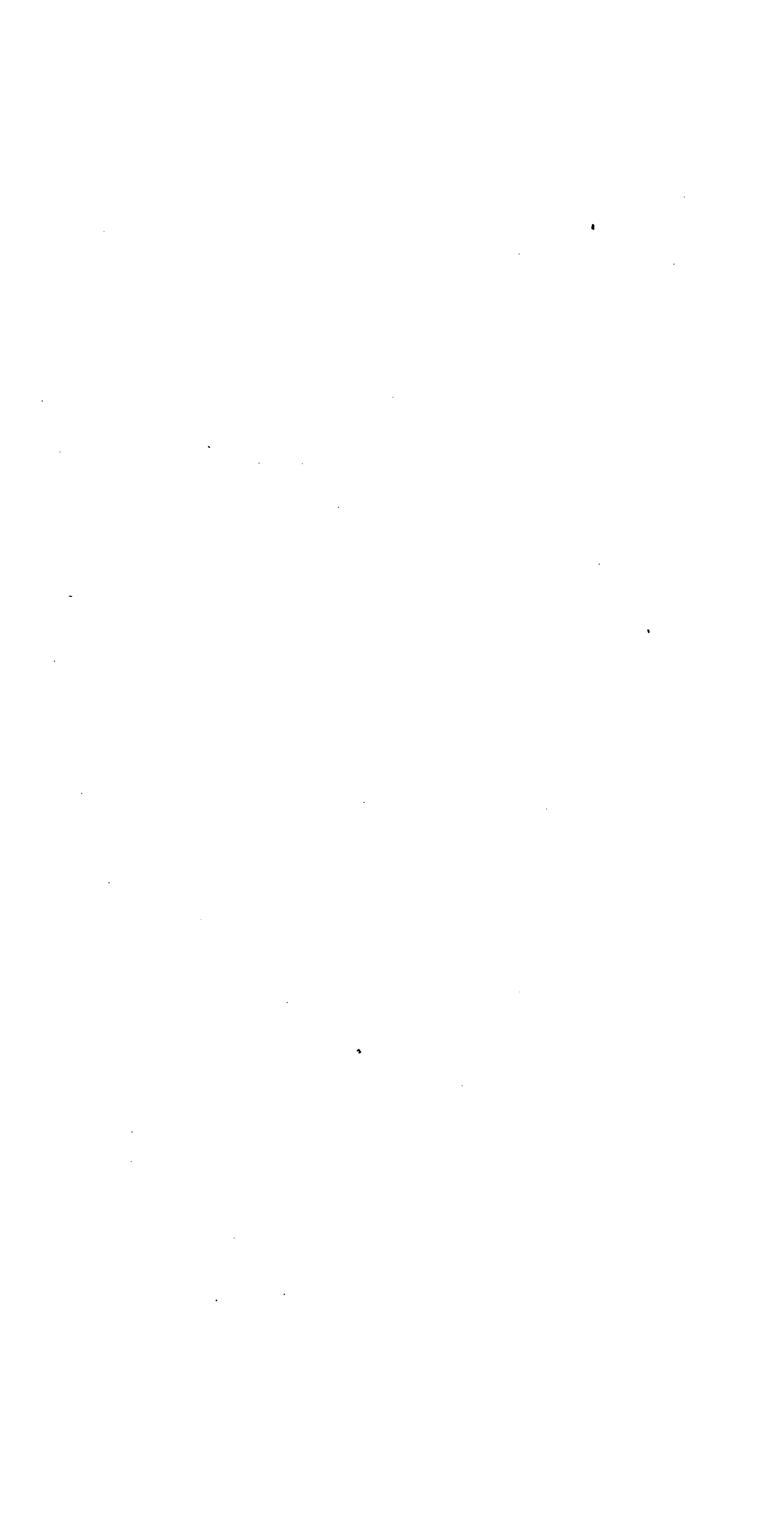
Ouvert en avril 1900, il a reçu d'abord 400 pensionnaires, puis

1) Le sikajy représentait, dans l'ancien système monétaire malgache, le huitième de la piastre, soit une valeur exacte de 0 fr. 625.

2) Jourdran, La lèpre et les léproseries à Madagascar. Ann. Hyg. et de Méd. coloniales. 1901. p. 541.

3) Pour la description des léproseries, j'ai consulté les Rapports sur le fonctionnement de l'assistance médicale à Madagascar en 1902 et en 1903 et l'excellent article de Jourdran, La lèpre et les léproseries à Madagascar. Ann. d'Hyg. et de Méd. coloniales. 1901. p. 541.


Léproserie de l'Emyrne Central (Ambohidratrimo) Echelle 1/6000.
Rocher
Paturage
Mur en terre
Cimetière
Inculte
Rizières
Terrain à manioc et à patates non planté
Tombeaux
Patates
Inculte
Patates
Inculte
Fossé
Fossé
Terrain à manioc et à patates
Digue
Rizières
Digue
Passerelle
Rizières
Antsangasanga (Rivière)
Rizières
Passerelle
Fossé
Mare
Ancienne route de Tananarive à Ankazobe
Pavillons des Femmes
Cour
Amphithéatre
Magasin
Pharmacie
Inculte
Parloir
Poste de Milice
Ligne de Poteaux télégraphiques
Chemin particulier
Chemin particulier
Rocher
Etable
Chapelle
Rochers
Economat
Logt du Docteur
Parloir
Poste de Milice
Cuisine
Enfants assistés
Ancien village
Ruines
Rocher
Cuisine
Rizières
Ananas
Arbres
Ruines
Ruines
Sentier public
Mare
Ruines
Mur en terre
Rizières
Sentier public
Rizières
Ruines
Mur en terre
Razafinmalala
Ambolomborona (Village)
Poste de Milice



I. Léproseries du plateau central.

Provinces		Léproseries	Nombre des lépreux internés
Tananarive.	Ville . . .	Ambohidratrimo.	750
	Province . .	Ramainandro.	110
Manjakandriana		Manankavaly.	250
Miarinarivo		Miarinarivo.	160
Antsirabé		Antsirabé.	750
Ambositra		Midongy.	150
Fianarantsoa		officielle.	229
		norvégienne.	12
		anglaise.	38
		pères jésuites.	55
		Total:	2504

II. Léproseries du littoral.

Provinces		Léproseries	Nombre des lépreux internés
Côte-Ouest.	Majunga . .	Case isolée.	100
	Ananalava .	2 cases isolées.	60
	Grande Terre	Cases isolées.	150
	Nossi-Bé . .	Nossi-Bé.	35
Côte-Est.	Farafangana.	Lazaristes.	450
		Total:	795

600 et enfin actuellement 750. Les bâtiments sont étagés sur trois terrasses dont les différences de niveau sont peu sensibles.

La terrasse supérieure est réservée aux religieuses qui sont logées dans un pavillon bien aéré et entouré d'un jardin. De cette position élevée, qui domine tout l' établissement, la surveillance est facile.

Sur la terrasse moyenne sont disposés les magasins et la pharmacie.

Sur la terasse inférieure, beaucop plus vaste que les deux autres, sont groupés les 26 pavillons destinés aux lépreux. Ils forment trois quartiers distincts: celui des hommes, celui des femmes, celui des enfants ou orphelinat. Ce dernier est lui même subdivisé en trois parties: la maternité, la section des enfants sains, la section des enfants lépreux.

Ces pavillons sont spacieux, bien ventilés et construits en brique. Chaque lit comprend un bâti rectangulaire en maçonnerie blanchi à la chaux, sur lequel est étendue une couchette en zozoros (espèce de jonc). La désinfection est peu coûteuse et facile à réaliser. Il suffit de badigeonner à la chaux le bâti et de changer le matelas. Des cuisines et des latrines sont aménagées auprès de chaque pavillon de malades.

Les familles ne sont pas désunies. Elles sont logées dans cases spéciales. Jusqu' à présent, les jeunes enfants étaient laissés à leurs parents. A l'âge de deux ans seulement, ils étaient placés à l'or-

phelinat. Aujourd' hui, les nouveau-nés sont enlevés à leur mère, aussitôt après l'accouchement. Ils sont élevés dans une partie distincte de la léproserie, sorte de nursery où ils sont nourris au biberon. Malgré ces précautions, deux enfants qu'on avait tenté de soustraire à la contagion familiale, en les séparant de leur mère le jour même de leur naissance, ont été reconnus atteints de lèpre pendant le cours de l'année 1902, et rendus à leurs parents lépreux. Quant aux enfants restés sains, ils sont gardés à l'orphelinat jusqu' à la puberté.

Au nord de l'établissement, la buanderie est établie sur un petit ruisseau qui ne déssert aucun village. Les linges et vêtements des malades sont lessivés à l'eau chaude dans un grand bassin.

Au bas du côteau, s'étendent des rizières, des champs de maïs, de manioc et de patates. L'ensemble des bâtiments et des terrains de culture qui en dépendent occupent une superficie de 60 hectares, dont 39 en rizierès. Toute la récolte est versée au magazin de la léproserie et sert à l'alimentation des malades.

La ration alloué aux internés est la suivante:

Tous les jours, riz ou manioc	Hommes	750	grammes
	Femmes	750	„
	Enfants	350	„
Une fois par semaine, viande	Hommes	250	„
	Femmes	250	„
	Enfants	125	„

Une fois par semaine également, des légumes ou du poisson sont distribués.

Les lépreux peuvent élever des volailles et des porcs pour améliorer leur ordinaire.

L'enclos est arrosé par une source claire et abondante dont le trop-plein se déverse uniquement dans les rizières de la léproserie.

Le service médical comprend: 1° un médecin des Troupes coloniales qui remplit les fonctions d'inspecteur et visite la léproserie une fois par semaine, 2° un médecin-résident indigène, 3° un auxilliaire indigène pour la pharmacie, 4° des religieuses franciscaines, au nombre de six, qui sont chargées de la surveillance générale, de la direction de l'orphelinat et des soins à donner aux enfants, 5° des infirmiers et des infirmières choisis parmi les lépreux valides.

L'internement est très strict. Les lépreux ne peuvent obtenir leur exeat que sur un certificat du médecin-inspecteur. Cette autorisation n'est délivrée qu'aux malades dont les ulcérations sont depuis longtemps cicatrisées.

Le chiffre des décès est très élevé. Il a été de 248 en 1902. Le cimetière est situé sur une montagne voisine.

Les frais d'entretien de l'établissement et des malades dépassent 60 000 francs par an.

Léproserie de Ramainandro.

Ce petit établissement pouvant contenir une centaine de malades sera prochainement supprimé; les lépreux seront transférés dans la nouvelle léproserie de l'Itaosy.

Léproserie de Manankavaly.

Elle reçoit les lépreux de la province de Manjakandriana. Installée à'Isovaina, au nord du village d'Alarobia, par les soins d'une mission anglaise, elle a été rachetée en 1900 par le service local et est actuellement au compte du budjet autonome de la province de Manjakandriana.

Cette léproserie, dont la superficie est de plus de 77 hectares, est éloignée de tout centre de population. Elle est établie sur un magnifique plateau, bien aéré, qui se prête merveilleusement à la culture de la pomme de terre et du manioc et qui est entouré de rizières situées dans les ravins environnants. Les dix corps de bâtiments élevés par la mission anglaise sont placés sur quatre rangées parallèles dont toutes les ouvertures sont orientées à l'ouest; le vent d'est étant des plus rigoureux sur ce plateau pendant l'hiver.

Une source d'eau vive qui descend des collines voisines pourra être facilement captée et suffire aux besoins de l'établissement.

Les anciennes constructions édifiées par la mission anglaise consistaient en longs bâtiments divisés en une série de compartiments comprenant chacun un rez-de-chaussée et un premier étage.

Les lépreux y étaient entassés dans de très mauvaises conditions hygiéniques. Le nombre des pavillons a été considérablement augmenté en 1901 et en 1902. Ils peuvent recevoir actuellement 400 pensionnaires et on se propose de faire encore d'importantes additions. Le nouveau type adopté est le suivant: bâtiment de 4 mètres de longueur sur 8 de largeur divisé par quatre murs transversaux en quatre compartiments. Chacun d'eux est percé d'une fenêtre et d'une porte, pourvu d'une cheminée, et peut loger cinq lépreux.

Des logements spéciaux sont affectés aux enfants des deux sexes.

A Manankavaly, comme dans les autres léproseries, les enfants séparés de leur mère dès la naissance, sont élevés au biberon dans une partie isolée de l'établissement, sous la surveillance des dames diaconesses.

Le service médical est assuré par un médecin-résident indigène, trois dames diaconesses, et des infirmiers, presque tous choisis parmi les lépreux relativement valides.

Le nombre des décès en 1902 a été de 26.

Une autre léproserie sera construite dans l'ancienne province d'Abatandrazaka pour recevoir 2 ou 300 lépreux. Les crédits nécessaires ont été inscrits au dernier budjet.

Léproserie de Miarinarivo.

L'ancien établissement, trop voisin du chef lieu, vient d'être remplacé par une nouvelle léproserie sur laquelle je ne possède aucun renseignement.

Léproserie d'Antsirabé.

Cet établissement appartient à la mission norvégienne, établie depuis plus de trente ans dans la localité. Il est composé de quatre villages entourés de champs de culture. Il est trop rapproché d'Antsirabé et la route du chef-lieu à Betafo traverse la léproserie. Les malades en profitent naturellement pour circuler sur la route et ailleurs.

La haute direction est confiée à un pasteur. Le rôle du médecin norvégien résident est très-éffacé. Le directeur du service de santé estime que, dans les conditions actuelles, cette agglomération de lépreux qui ont toute latitude pour rayonner au loin n'a qu'un caractère purement humanitaire et confessionnel et nullement de défense. Le médecin des troupes coloniales chargé de l'inspection a fait à plusieurs reprises des représentations, mais son droit de contrôle étant mal déterminé il ne possède pas toute l'autorité nécessaire pour faire écouter ses avis. Toutefois, par convention du 19 avril 1900, la mission norvégienne s'est engagée à recevoir tous les lépreux de la province de Betafo moyennant un versement annuel de 40 francs par pensionnaire [1]). De ce fait, la léproserie est devenue établissement officiel et le directeur du service de santé de la colonie s'efforce de faire prévaloir, ici comme ailleurs, le principe de l'isolement absolu. Les mesures suivantes seront prochainement mises en vigueur:

1. Détourner la route qui traverse la léproserie;
2. Etablir autour des villages de lépreux, dont l'ensemble constitue la léproserie d'Antsirabé, une clôture naturelle en cactus ou en toute autre plante du même genre;
3. Inviter la direction de l'établissement à signaler les évasions, à restreindre les visites des parents et d'une manière générale à rendre l'isolement aussi strict que possible;
4. Réviser le contrat passé avec la mission norvégienne en renforçant le droit de contrôle de l'Administration.

Le nombre de lépreux internés à Antsirabé a été de 587 en 1901, de 671 en 1902, de 750 en 1903. En 1902, il y a eu 200 entrées et 136 décès.

Les enfants de lépreux sont élevés dans un orphelinat, où ils sont placés à l'âge de deux ans; ils étaient au nombre de 29 en 1902 (17 garçons et 12 filles).

Le directeur du service de santé a fait le relevé des enfants nés à la léproserie depuis trois ou quatre ans: sur 44 enfants, 18 sont morts et 4 out été récemment reconnus lépreux; ce qui donne pour le moment un déchet de 50%. Cette proportion s'accroîtra encore dans la suite, car c'est surtout de 10 à 20 ans qu'on voit apparaître les premiers signes apparents de la lèpre chez les descendants de lépreux.

Une léproserie officielle est en voie de construction. Quand elle sera terminée, elle pourra recevoir tous les lépreux de la province dont 250 environ sont encore en liberté; il est probable que l'établissement de la mission norvégienne disparaîtra à cette époque.

Léproserie de la province d'Ambositra.

En 1902, la construction d'une léproserie fut décidée; mais, pour divers motifs, il n'a pu ètre donné suite à ce projet.

La création à bref délai de cette formation sanitaire s'impose et

1) Un arrèté du gouverneur général de Madagascar établit une taxe au profit des lépreux: „Chaque habitant de la province de Betafo, inscrit au rôle de la taxe personnelle sera soumis à une taxe spéciale de 0 Fr. 65 Centimes par an .... Elle sera destinée à faire face à la subvention annuelle à allouer à la mission norvégienne."

il est inutile de s'appesantir sur la nécessité impérieuse de recueillir tout en partie des 800 à 1000 lépreux qui errent dans la province.

Justemment préoccupé de cette question, le directeur de l'assistance médicale a envoyé, sur lieu, le médecin-inspecteur de la province d'Antsirabé qui, d'accord avec l'administrateur, a choisi un emplacement et fait les propositions nécessaires. Il est situé dans une magnifique vallée, à 15 kilomètres d'Ambositra et à 7 ou 8 kilomètres de tout centre habité.

L'alimentation en eau sera facile. Le terrain est très vaste et la majeure partie pourra être transformée en rizières; les malades les moins mutilés pourront occuper leurs loisirs en se livrant à la culture ce qui allègera les charges de l'assistance médicale.

Toutes les précautions seront prises pour les eaux souillées par les lépreux qui subissent une filtration à leur sortie de l'établissement.[1])

Léproseries de la province de Fianarantsoa.

Elles sont au nombre de quatre: une officielle et trois appartenant à différentes missions.

Léproserie officielle. — Elle est située à 4 kilomètres au Sud-Est de Fianarantsoa. C'est un beau domaine d'environ 87 hectares. Les habitations occupées par les lépreux sont de deux types différents. Les maisons du type 1900 forment une série de vingt cases divisées chacune en deux chambres par une cloison médiane. Chaque chambre peut recevoir un ménage de lépreux, soit environ quatre à cinq personnes.

Les maisons du type 1901—1902, beaucoup plus confortables que les premières, se composent de quatre compartiments ayant tous une cheminée d'angle. Une fenêtre et une porte assurent la ventilation de chaque chambre. Toutes ces maisons ont été plafonnées, l'expérience ayant démontré que les lépreux contractent facilement des lésions pulmonaires graves quand la température s'abaisse.

Aux bâtis de briques recouverts de claies de jonc, qui étaient trop froids, on a substitué des lits en bois, sur la demande des malades.

Un peu en dehors du village lépreux sont situés les bâtiments de l'infirmerie et les magazins. Le logement du surveillant général s'élève sur un plateau.

Chaque lépreux possède un lopin de terre dont les produits lui appartiennent. Il récolte du manioc, des patates, des bananes et des fruits, et ces plantations sont d'autant plus prospères que l'eau coule en abondance dans l'enceinte de la léproserie. Encore quelques années et toutes les hauteurs seront boisées. Quant aux rizières, les lépreux ont du renoncer à les cultiver, parce que leurs ulcérations mises en contact avec la vase deviennent rapidemment phagédéniques. Les malades élèvent des volailles et l'établissement entretient un troupeau de boeufs.

Le mouvement de la léproserie est le suivant: en 1902, 199 internés, parmi lesquels 27 sont morts et 15 ont obtenu l'autorisation de rentrer dans les léproseries des missions; 151 étaient encore présents au 31 décembre (89 hommes et 62 femmes).

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1) Cette léproserie située à Midonjy à été ouverte à la fin de 1903. Elle abrite actuellement 150 lépreux.

En 1903, 229 lépreux internés, dont 29 moururent dans l'année; au 31 décembre, il restait à l'établissement 190 lepreux (96 hommes, 72 femmes et 22 enfants).

En 1902, on a enregistré quatre accouchements à terme sur sept grossesses. Les nouveau-nés ne portaient aucune trace de lèpre. — En 1903, douze grossesses ont donné naissance à sept enfants dont deux sont décédés. Il y a donc eu cinq avortements.

Le nombre des évasions qui, en 1902 n'était que de 6, est monté à 10 en 1903 à la suite de l'interdiction d'inhumer des cadavres en dehors du cimetière de la léproserie. L'administration ayant déclaré que les parents seraient autorisés à transporter les ossements dans les tombeaux de famille, un certain nombre d'années après l'inhumation, les lépreux rassurés ne cherchent plus à fuir.

Le prix de revient de la journée d'un lépreux est de 0 franc 30 centimes environ, non compris les frais de construction et les travaux de réparation.

Léproserie anglaise. — L'établissement de la London Missionary Society a été construit en 1895. Il est situé à cinq kilomètres environ de Fianarantsoa et à un kilomètre de la léproserie officielle. Il comprend cinq bâtiments contenant 18 chambres d'habitation et un temple.

Trente-huit lépreux sont actuellement en traitement. Chaque famille occupe une chambre distincte.

Les dépenses s'élévent à la somme de 1300 francs; elles sont couvertes par un don annuel de 250 francs et par des aumônes.

Léproserie norvégienne. — Elle n'hospitalise plus qu'une douzaine de malades et ne reçoit plus de nouveaux pensionnaires. Elle est appelée à disparaître dans un avenir prochain.

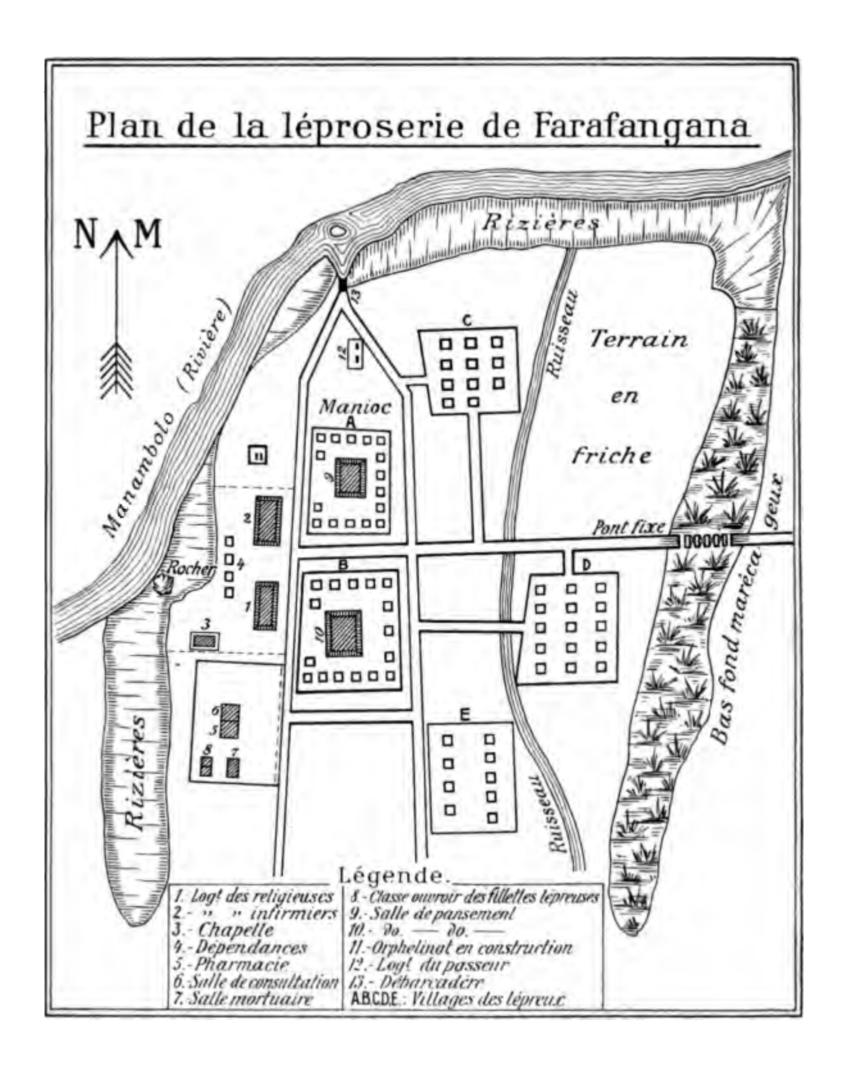
Les lépreux vont à l'école et suivent les exercices du culte. Le riz, le manioc et les patates nécessaires à leur alimentation proviennent des terres de la léproserie et des aumônes. Chaque malade reçoit 0 franc 30 centimes par semaine pour achat de viande.

Un dame diaconesse et un missionnaire assurent le service.

Léproserie des Jésuites. — Située à cinq kilomètres à l'ouest de Fianarantsoa, sur un plateau portant le nom de Mararono. Elle comprend un bâtiment unique de 50 mètres de longueur sur 8 mètres de largeur. De part et d'autre de la chapelle, qui occupe le centre, court une véranda formant cloître sur lequel s'ouvrent toutes les cellules au nombre de huit de chaque côté, soit 16 en tout. Ce bâtiment n'a qu'un rez-de-chaussée.

Le chiffre des pensionnaires est de 50 à 60. Ils vivent en commun et en famille. Ils tirent leur subsistance en partie du fruit de leur travail qui est rétribué, en partie des dons faits par la mission à laquelle chaque lépreux coûte environ 50 francs par an.

L'anncienne léproserie étant en assez mauvais état, les Jésuites ont décidé de construire un nouvel établissement qui aura des proportions monumentales. L'emplacement, très voisin de la léproserie actuelle, est fort bien choisi. Il est suffisamment ventilé et à l'abri du vent régnant, du vent d'Est, si nuisible aux lépreux. L'eau coule en abondance sur le plateau, avantage inestimable pour une léproserie.


Plan de la léproserie de Farafangana
N M
Rizières
Manambolo (Rivière)
Ruisseau
Terrain
en
friche
Manioc
A
B
C
D
E
Rocher
Pont fixe
Bas fond marécageux
Rizières
Ruisseau
Légende.
1. Logt des religieuses
2.- " " infirmiers
3.- Chapelle
4.- Dépendances
5.- Pharmacie
6. Salle de consultation
7. Salle mortuaire
8.- Classe ouvroir des fillettes lépreuses
9.- Salle de pansement
10.- do. — do. —
11.- Orphelinat en construction
12.- Logt du passeur
13.- Débarcadère
ABCDE: Villages des lépreux



Les Jésuites ont l'intention de séparer les sexes. Ils ont construits à cet effet deux grands corps de bâtiments affectés l'un aux hommes, l'autre aux femmes. Aucune communication ne peut avoir lieu entre ces deux catégories de malades. Il est probable que cet établissement sera en état de recevoir deux cents lépreux dans le courant de l'année 1904.

Les statistiques accusent dans la province de Fianaronzoa la présence de 600 lépreux, (chiffre probablement au-dessous de la vérité), qui sont, dès à présent, pour la plupart hospitalisés.

Léproserie de Farafangana. Tafel III.

Parmi les léproseries qui désservent les provinces de la côte, il en est une, celle de Farafangana, dont l'aménagement mérite d'être décrit.

Le nombre des lépreux de cette province n'est pas moindre de 3000. C'est particulièrement sur le littoral qu'ils abondent. Vient en première ligne le district de Vangaindrano, puis ceux de Farafangana, d'Ankarana, de Vondrozo etc.

La population Antaimoro, encore murée dans ses antiques coutumes musulmanes et strictement parquée sur les côteaux de Vohipeno paraît un foyer de contamination qu'il faudrait assainir par l'expropriation. Dans une province aussi peuplée (280 000 h.) et aussi floristante, l'assistance au lépreux devait être organisée à bref délai. Par suite d'un contrat passé en février 1902 entre le général Galliéni, gouverneur général de Madagascar et l'évêque des provinces du sud, la mission des Lazaristes s'engage à créer à ses frais sur le terrain qui lui est concédé à Ambatoabo, un établissement destiné à recevoir les lépreux. Il est accordé, à la mission outre une somme pour frais de première installation, une subvention annuelle de 60 francs par lépreux hospitalisé.

La léproserie est située au sud-est de la ville de Farafangana, sur la rive droite de la Manambato, au sommet d'un mamelon verdoyant dont le pied est baigné par un coude de la rivière. Vingt-cinq hectares de terre arable ont été attribués à l'établissement. Deux sources abondantes et un ruisseau qui n'est jamais à sec suffisent amplement aux besoins des lépreux, de sorte qu'il est rigoureusement interdit à tout malade de puiser de l'eau dans la Manambato, d'y laver son linge ou d'y faire ses ablutions.

Les eaux des sources et du ruisseau qui pourraient être contaminées ont été détournées et se perdent dans les rizières de la léproserie.

Sur le côteau d'Ambatoabo souffle régulièrement le vent sud, sud-est, pendant la saison fraiche, le vent nord, nord-est pendant la saison chaude.

Une large route dirigée du Nord au Sud sépare nettement les bâtiments destinés au personnel des villages des lépreux. A droite de la route, et dominant la rivière, le logement des soeurs de St. Vincent de Paul, grande case en falafa recouverte en tôle, exhaussée au-dessus du sol d'un mètre environ, et pourvue d'une véranda sur ses quatre façades. Lui faisant vis-à-vis, le logement des infirmières laïques,

bâti sur le même modèle; puis s'étendent les dépendances: réfectoire, greniers à riz, cuisine, communs etc. Tous ces bâtiments, y compris la chapelle, sont isolés par une clôture circulaire en rondins jointifs. Du même côté droit de la route, mais en dehors de cette enceinte, sont disposés: la pharmacie, la classe et l'ouvroir des fillettes lépreuses. Le côté gauche de la route est occupé par cinq villages. Deux d'entre eux très importants sont situés à proximité des bâtiments de l'Administration. Ce sont les villages des infirmes (hommes au nord, femmes au sud), au centre desquels s'élèvent deux salles de pansement fort bien aménagées, avec claire-voies circulaires et portes-fenêtres pour l'aération, avec canalisation pour l'écoulement des eaux usées. Dans ces deux villages, de nombreuses cases abritent les invalides et les infirmes qui ne pourraient venir chaque matin pour se faire panser.

A une plus grande distance de la route, sont échelonnés du Nord au Sud trois villages spacieux donnant asile aux lépreux que la maladie n'a pas trop mutilés. Dans chaque agglomération, les cases au nombre d'une vingtaine sont correctement alignées et espacées les unes des autres de dix mètres pour limiter les ravages du feu, en cas d'incendie. Des allées plantées d'eucalyptus et de cocotiers séparent les habitations auxquelles on accède par des routes plates et faciles.

Les cases ne diffèrent pas sensiblement des habitations de la côte. Chacune d'elles, construite en falafa, avec vérandas sur deux faces, est élevée de cinquante centimètres au-dessus du sol. La toiture a une pente suffisante pour permettre l'écoulement rapide des eaux de pluie. L'air est sans cesse renouvelée par les portes percées sur les façades Est et Ouest. Les planchers en rapaka et recouverts de nattes sont fréquemment lavés.

Une salle d'isolement pour les maladies épidémiques, un dépôt mortuaire complètent la léproserie. Les malades savonnent eux-mêmes leur linge dans le ruisseau dont l'eau alimente les rizières. Les objets de pansement hors d'usage sont incinérés et mis en terre.

Le personnel comprend: la supérieure de la mission, quatre soeurs de St. Vincent de Paul, dont une est chargée des enfants lépreux et de l'atelier de couture, deux infirmières laïques qui exécutent les pansements et donnent aux malades les soins nécessaires.

Le lépreux a le droit de désigner le village où il veut vivre, et de choisir ses compagnons de chambre. La cohabitation des époux est autorisée, mais le mariage est rigoureusement refusé aux célibataires.

Dès le matin, les valides vont cultiver leur champ dont la récolte leur appartient.

A dix heures, ils assistent à la distribution des aliments pour la journée:

Tous les jours: riz . . .	Hommes	750 g
	Femmes	750 „
	Enfants	630 „
Dimanche et Fêtes: viande	Hommes	300 g
	Femmes	300 „
	Enfants	150 „

Dans la journée, a lieu la visite médicale.

Chaque lépreux est pourvu d'une couverture en laine grise qu'il utilise comme lamba pendant la saison fraîche et qui sert à son couchage.

L'internement est absolu. Aucun lépreux ne peut sortir, mais des autorisations spéciales sont accordées aux parents qui peuvent, à jour fixe, venir visiter leurs malades.

L'état sanitaire des lépreux internés est en général satisfaisant, bien que le nombre des phtisiques atteigne 10 %. Durant l'année 1903, il y a eu 18 décès sur 430 internés, soit 4,1 %, et 8 naissances. Les enfants ont été laissés à leur mère, mais dans l'avenir l'ouverture d'une nursery permettra d'élever les nouveau-nés loin de tout contage.

Les dépenses pour l'entretien de la léproserie de Farafangana ont été, dans la période 1902—1903, d'une quarantaine de mille francs.

Léproseries projetées.

Il est question d'ouvrir trois nouveaux établissements:

Un pour la côte Sud-Ouest, car la petite léproserie norvégienne située près de Morondava n'abrite qu'une trentaine de malades;

Un pour la côte Nord-Ouest, situé dans l'île de Nossi-Bé;

Un dans la province de Fénérive pour isoler les lépreux de la côte Nord-Est.

En résumé, Madagascar est la seule colonie française où la lutte contre la lèpre ait été engagée avec énergie, conviction et persévérance. Tout l'honneur en revient au général Galliéni et au Corps de Santé des Troupes Coloniales qui, en accomplissant cette oeuvre humanitaire, se sont acquis des droits à la reconnaissance du monde civilisé.

Le nombre des lépreux reconnus officiellement à Madagascar dépasse le chiffre de 8000 sur une population évaluée à 1,600 000 habitants. Aujourd'hui, huit ans après la conquête, près de la moitié de ces malheureux sont internés, ou plutôt hospitalisés, car ils sont traités non comme des prisonniers, mais comme des malades.

Malgré ces résultats dont la France peut à bon droit s enorgueillir, il reste beaucoup à faire. Si, en principe, tout indigène atteint de la lèpre doit être envoyé d'office dans une léproserie, en pratique, les malades qui peuvent subvenir à leurs besoins achètent facilement le silence des gouverneurs indigènes. Il faut en outre reconnaître que dans les provinces du littoral, où l'organisation de l'assistance médicale est encore à l'état rudimentaire les établissements d'isolement sont rares et insuffisants de sorte que la majeure partie des lépreux vivent encore en liberté.

L'internement est ordonné par décision du chef de la province, après un examen médical fait par le médecin-inspecteur qui a dans ses attributions la surveillance des léproseries officielles ou privées.

En cas de doute, les sujets suspects sont mis en observation et, chaque fois que cela est possible, on a recours à l'examen bactériologique de la peau, du mucus nasal ou vaginal.

La surveillance et la direction administrative des léproseries incombent au chef de la province. Dans chaque établissement, le service médical, sous la haute autorité du médecin-inspecteur, est confié à un médecin-résident indigène qui est assisté par des religieuses et des infirmiers choisis de préférence parmi les lépreux encore valides.

L'internement est absolu. Aucun malade ne peut franchir l'enceinte de la léproserie, mais les parents, sous certaines conditions, sont autorisés à visiter leurs proches. Les sexes sont séparés; mais, si le mariage entre lépreux est interdit, on ne désunit pas les époux. Les enfants, dès leur naissance, sont transportés dans un orphelinat annexé à chaque établissement, où ils sont soumis à l'alimentation artificielle.

Les léproseries de Madagascar sont de véritables colonies agricoles où les malheureux peuvent cultiver des terres et se grouper en villages, ce qui leur donne l'illusion de la liberté.

Chapitre 4: **Archipel des Comores.**

Population ainsi répartie: Mayotte: 1 800 habitants; — Grande-Comore: 44 000 h; — Anjouan: 15 000 h; — Mohéli: 8000 h; — Total: 85 000 h.

La création d'une léproserie à Anjouan serait un bienfait pour la colonie. Les habitants pourchassent les lépreux qui se réfugient à Chicoundouni, en face de l'ilôt de la Selle, où existe un petit village de lépreux. Les malades ne s'y rendent qu' à une période avancée. Ils y vivent du produit de leurs plantations: riz, manioc, fruits etc.; personne ne leur vient en aide. L'isolement dans ce village est illusoire.[1])

La lèpre est fréquente à Mayotte. On a fait subir une visite médicale à la population de l'île et l'on a envoyé les indigènes reconnus lépreux à la léproserie de l'île M'Zambourou. Il est question de procéder de même dans les autres îles de l'archipel. Les lépreux de la colonie toute entière seraient réunis à M'Zambourou.

Cette petite île est située au nord de Mayotte et séparée d'elle par un bras de mer de 4 milles environ. C'est là que, depuis quelque trente ans déjà, la léproserie de Mayotte est installée.

A part la crique où les lépreux s'abritent, les berges de cette île volcanique sont partout à pic, rendant ainsi toute escalade, comme toute fuite, impossible. Il n'y a qu' une source qui coule sur le versant nord, c' est l'unique point d'eau où les lépreux viennent se désaltérer.

Les internés sont au nombre de 72: 14 femmes et 58 hommes. Ils ont élu l'un d'entr'eux chef de leur république. Répartis en deux villages, Mounta Coundia et M'sanga, situés sur le flanc occidental de l'île, ces malheureux habitent, par familles ou groupes sympathiques, des cases d'une exquise propreté qu'ils se sont bâtis eux-mêmes. Entre les rochers, sur un fond de sable caillouteux où l'humus est rare, les lépreux cultivent un peu de manioc.

L'administration leur envoie des outils: pioches, couteaux, hameçons etc. . . . ., du linge, du tabac, des médicaments et des vivres[2]).

Chapitre 5. — **Ile de la Réunion**[3]).

La lèpre est disséminée partout, mais les quartiers les plus cou-

1) Lafont, L'ile d'Anjouan. Ann. d'Hyg. et de Méd. coloniales 1901. p. 181.
2) Blin, Léproserie de M'Zambouron. Extrait d'un article de la Dépeche coloniale illustrée sur Mayotte et les Comores (31. Mai 1904).
3) Merveilleux, La lèpre à l'île de la Réunion. Ann. d'Hyg. et de Méd. coloniales 1993, p. 232.

taminés sont: Saint-Leu, Saint-Gilles et Saint-Louis. Dans ce dernier c'est la Rivière qui compte le plus grand nombre de malades.

„Attendu les progrès toujours croissants de la lèpre, considérant qu'il importe de préserver la population agricole d'un fléau qui menace de l'atteindre" un arrêté local du 25. février 1875 prescrit: 1. qu'une léproserie sera créée; 2. que tout individu désigné comme lépreux sera tenu de se présenter à la Commission sanitaire; 3. que tout individu reconnu lépreux par la dite Commission sera immédiatement séquestré à la léproserie; 4. que pourra être dispensé de cette obligation tout lépreux qui s'engage à quitter la colonie, ou qui justifierait de moyens suffisants pour recevoir, dans sa famille, les soins que réclament son état.

Cette autorisation ne sera accordée qu' à la condition expresse d'une séquestration absolue dont l'inexécution entrainera de plein droit la mesure prescrite au § 3.

Cet arrêté draconien n'est pas appliqué. Nombre de lépreux circulent dans les rues et montent dans les wagons. Toute enquête médicale serait impossible, car la maladie s'est infiltrée parmi les métis et les blancs qui s'opposeraient à toute recherche dans les familles. Aussi la lèpre gagne-t-elle constamment du terrain.

La léproserie de la Montagne est située à 15 kilomètres de Saint-Denis la capitale, sur un vaste plateau de 400 m d'altitude. En 1903, il y avait en traitement dans cet établissement 61 pensionnaires: 54 hommes et 7 femmes. Pendant la période quinquennale 1897—1901, 126 malades sont entrés à la léproserie et 76 sont morts: soit 1 décès sur 2, 25 malades.

Chapitre 6. — **Antilles françaises.**

En 1725, la lèpre était devenue tellement menaçante à la Guadeloupe que les colons réclamèrent la séquestration des lépreux. En 1728, une inspection générale de tous les habitants de l'île fut ordonnée. Cette visite fit découvrir 125 lépreux dont 22 blancs, 6 mulâtres et 97 nègres sur une population de 43000 habitants environ. Une léproserie fut créée dans la petite île de la Désirade, située à deux lieues de la côte la plus proche de la Guadeloupe et l'on y transporta, sans aucune distinction de races, tous les lépreux.

Cet établissement subsiste encore aujourd'hui, et c'est vers lui que sont dirigés les lépreux des Antilles françaises (Martinique, Guadeloupe etc.) qui en font la demande.

L'aménagement des bâtiments, divisés en cellules étroites, est plutôt celui d'une prison que d'un hospice. Le nombre des internés était de 85 en octobre 1902. Bien que les sexes soient séparés en principe, il naît quelques enfants à la léproserie. M. Noël, le médecin-directeur, les fait transporter aussitôt après l'accouchement dans un bâtiment à part. Toutes les trois heures, pendant le jour, ils sont aportés à leur mère dont le sein préalablement aseptisé est garni d'une tâtière en caoutchouc. Aucun des enfants ainsi élevés, dont le plus âgé il est vrai n'a que dix ans, n'est attaint de la lèpre[1]).

1) Noël, Douze années de pratique à l'hospice des Lépreux de la Désirade Thèse de Paris. 1903.

Chapitre 7. — **Guyane française.**[1])

Depuis les mémoires de Bajon sur Cayenne (1777) et le travail de Poissonnier-Despérière sur le mal rouge (1785), on a beaucoup écrit sur la lèpre en Guyane.

De 1823 à 1891, date du dernier décret théoriquement en vigueur, il n'a pas été pris à son sujet moins de vingt décisions qui reflètent les fluctuations de l'opinion publique de la colonie, alternativement portée de l'extrême faiblesse à l'extrême sévérité.

En 1824, une léproserie existait déjà à l'île du Diable (groupe des îles du Salut). Mais comme l'eau douce y fait défaut et que la terre ne se prête pas à la culture, la léproserie fut transférée, par décision du 18 Mars 1833, à l'Acarouany où elle est encore actuellement située.

Jusqu'à cette époque, les mesures de rigueur visaient exclusivement les esclaves noirs. Mais la lèpre, faisant beaucoup de ravage parmi la population blanche, un décret du 24 aoû 1840 préscrivit la création d'une seconde léproserie sise à l'îlet „la Mère" où toute personne de condition libre atteinte de lèpre devrait être internée. Ce texte resta lettre morte.

En 1891 fut promulgé un nouveau décret dont les principales dispositions sont le suivantes:

Article premier. — Seront admises à la léproserie située à l'Acarouany toutes les personnes malades de la lépre qui en feront la demande.

Y seront envoyées d'office, après un temps d'observation .... toutes celles qui, étant reconnues atteintes de lèpre, n'auraient aucun moyen de se soigner, tels que les vagabonds, les mendiants, les gens sans asile et sans ressources, ainsi que les condamnés.

Les personnes de condition aisée qui voudront se soigner à domicile et à leurs frais devront s'isoler à une distance de deux kilomètres au moins de Cayenne et d'un kilomètre des bourgs.

Article 2. — L'état de maladie de la personne sera constaté par deux médecins civils ou militaires.

Ce décret n'a jamais été abrogé, mais jusqu'à présent, il n'a pas été suivi d'un commencement d'exécution.

Et cependant, dit M. Clarac[1]), la lèpre est pour la Guyane et pour Cayenne en particulier un véritable fléau. Elle s'infiltre progressivement, attaquant chaque jour des familles blanches jusque là indemnes. D'après M. Pain, exerçant depuis plus de vingt ans dans la colonie, il y a au moins 200 lépreux à Cayenne pour une population de 12000 habitants. En sept ans de séjour, M. Lafaurie a constaté 8 nouveaux cas dans le bourg de Mana sur 1602 habitants. Dans l'élément pénal comprenant 8515 individus dont 7000 européens environ, on compte 35 cas de lèpre. D'après M. Clarac, le nombre des lépreux dans la Guyane française n'est pas moindre de 350, ce qui donne le pourcentage de 11,66 ‰[2]).

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1) Clarac. La lèpre à la Guyane. Ann. d'Hyg. et de Méd. coloniales. 1902. p. 76—88.

2) Il n'y a pas d'exemple authentique de lèpre sur les Peaux-Rouges qui vivent à l'écart. Toutes les autres races sont atteintes.

Non seulement le décret de 1891 n'est pas appliqué, mais aucune ntative n'est faite pour contenir la lèpre dans ses limites actuelles. es lépreux avérés excercent, au vu et au su de tous, la profession de ›ucher, de boulanger, de blanchisseuse etc.; ils puisent avec leurs ains mutilées et suppurantes aux sources qui alimentent la population ,ine.

Dans les familles entâchées de lèpre, aucune précaution n'est ·ise pour protéger la descendance. Aussi nombre de familles blanches nt décimées par la lèpre. M. Clarac a publié plusieurs arbres généogiques qui démontrent qu'en Guyane comme ailleurs la lèpre acharne sur certaines familles douées d'une hérédité de prédispotion. Des parents sains confient, par insouciance ou ignorance, leurs ›uveau-nés à des nourrices noires qui n'ont été soumises à aucun ‹amen médical. Delà, des malheurs irréparables dont voici un ‹emple: Un Lyonnais s'établit en Guyane; il ne devient pas preux et il se marie à une blanche également indemne de lèpre. eur fils s'unit à une française originaire du département du Loir-et-·her. J'ai pu m'assurer que ni l'un ni l'autre n'est atteint de la lèpre. ›r, ils ont cinq enfants, dont les trois premiers sont lépreux. D'héré-ité, il ne peut être ici question. Dans ce cas, la maladie a été évilemment introduite dans cette famille par une négresse qui a élevé 'aîné de ces enfants et qui est morte plus tard de la lèpre.

M. Clarac ajoute encore à la liste des causes qui favorisent l'ex-‹ension de la lèpre:

1. Le lavage en commun du linge des lépreux et des per-›onnes saines;

2. Le prêt, par la Bibliothèque publique, des livres qui sont em-›ortés à domicile et peuvent être feuilletés par les doigts ulcérés de ›preux;

3. Les contacts multiples directs ou indirects des enfants dans ›s écoles.

M. Clarac, en moins de deux ans, à fait renvoyer 6 écoliers dont étaient atteints de lèpre avérée. Beaucoup de ces enfants boivent ı robinet des fontaines, et ceux qui ont un gobelet personnel le prè-›nt volontiers à leurs petits camarades.

Rien ne serait plus facile que d'interner de gré ou de force les ıgabonds et les condamnés, par application du décret de 1891. ·ais des difficultés commencent quand il s'agit de rechercher les ma-·des dans leur famille. La population tout entière serait hostile à ›ute tentative de dénombrement des lépreux. Passer outre, fomenterait n soulèvement général des familles blanches indemnes ou contaminées.

Etant donné cet état d'esprit, les autorités sont impuissantes et ›s prescriptions du décret restent sans effet. A la léproserie destinée recevoir les malades de la population libre, il n'y avait, en janvier 900, que 31 internés, presque tous des immigrants sans famille ou es indigents incapables de gagner leur vie[1])

1) Ces 31 lépreux appartenaient aux races les plus diverses: 13 nègres ou égresses; — métis; — 9 immigrants hindous; — 1 annamite; — 3 européens ·rovenant de la rélégation.

Cet établissement est situé sur la rivière Acarouany. Il est distant d'une trentaine de kilomètres du bourg de Mana, par voie fluviale, et de 200 kilomètres de Cayenne par mer. Le choix de l'emplacement, dit M. Lafaurie, est très heureux: c'est un vaste plateau d'une salubrité incontestable, élevé de 17 mètres au-dessus de la rivière et par conséquent pourvu d'eau douce en abondance. Les terres de culture sont nombreuses. L'isolement est complet et la surveillance facile, car une ceinture de bois impénétrables et de savanes noyées entourent de toutes parts la léproserie qui ne communique que par eau avec Mana, son centre de ravitaillement.

Dans quelques bâtiments en planches sont entassés, sans égard pour les affinités de race, les malheureux que la faim a poussé à entrer dans cet asile.

M. Lafaurie, qui a été longtemps le médecin de cette léproserie, a proposé les réformes suivantes qui me paraissent fort judicieuses:

Les malades seraient divisés en trois catégories.

a) Les valides se livreraient à la culture, ils se grouperaient à leur guise, au nombre de 4 à 6, dans des cases qu'ils construiraient au besoin eux-mêmes;

b) Les lépreux encore capables d'effectuer quelques petits travaux seraient aussi répartis dans des cases autour desquelles ils cultiveraient des plantes potagères;

c) Les malades infirmes seraient réunis dans un bâtiment unique où ils seraient assistés par des infirmiers choisis parmi les lépreux de la première catégorie.

M. Lafaurie demande en outre la création d'un parc à bestiaux, afin de distribuer aux malades du lait et de la viande fraîche en remplacement des salaisons, et en particulier du bacalian, sorte de morne salée, qui est à peu près la nourriture exclusive des pensionnaires de l'Acarouany.

Les lépreux de la population pénale sont internés dans une des îles du Maroni, l'île Saint-Louis: sur 30 malades, on compte 20 blancs, les autres sont des arabes, des noirs ou des indiens.

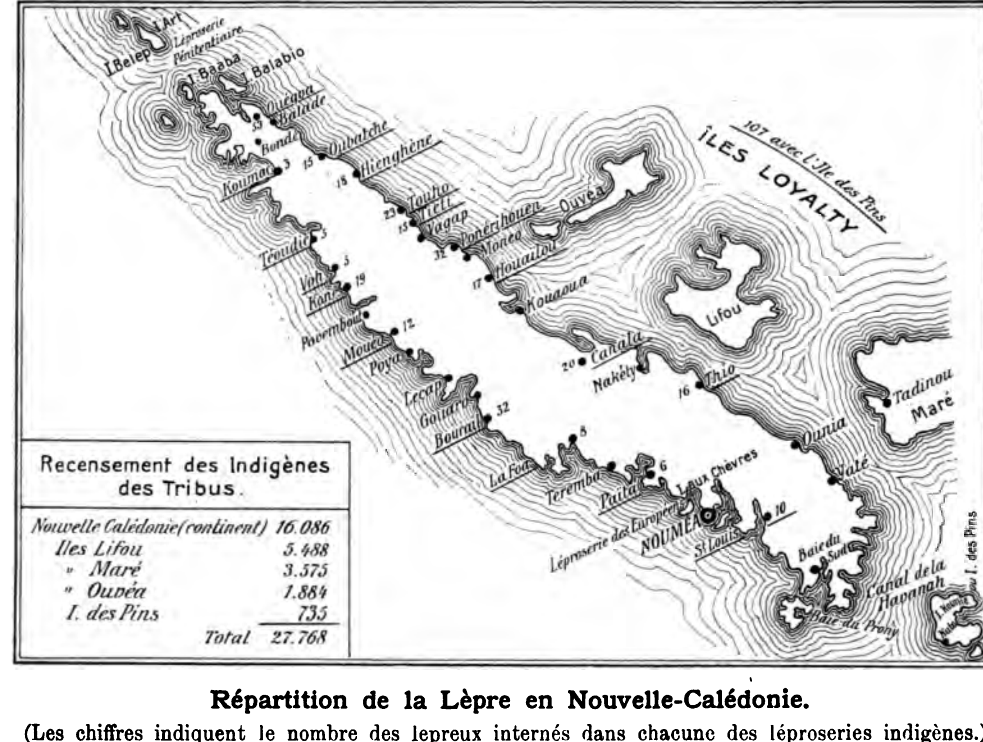
Pour vaincre la résistance de la population, il faut d'une part l'instruire des dangers de la contagion, cette tâche incombe au médecin, il faut d'autre part ouvrir un asile, au moins décent, où tout lépreux consente à se réfugier, c'est le devoir des autorités administratives.

J'adresse mes remercîments à M. le Gouverneur Picanon, qui a bien voulu répondre avec une extrême obligeance au questionnaire que je lui avais envoyé.

Chapitre 8. — **Nouvelle Calédonie**[1]. Tafel IV.

Chez les Canaques, la lèpre s'est répandue avec une rapidité foudroyante. D'après la tradition des indigènes, confirmée par l'opinion des missionnaires et des anciens administrateurs, l'apparition du fléau remonte à cinquante ans environ. Cependant la Colonie n'a été officiellement

1) Auché, La lèpre en Nouvelle-Calédonie. Archives de Méd. navale, janvier-juin 1899. Tiré à part de 180 pages. — Primet, La prophylaxie de la lèpre en Nouvelle-Calédonie. Ann. d'Hyg. et de Méd. coloniales. Oct.-Nov.-Déc. 1901.



Recensement des Indigènes des Tribus.	
Nouvelle Calédonie (continent)	16.086
Iles Lifou	5.488
" Maré	3.575
" Ouvéa	1.884
I. des Pins	735
Total	27.768

Répartition de la Lèpre en Nouvelle-Calédonie.

(Les chiffres indiquent le nombre des lepreux internés dans chacune des léproseries indigènes.)



reconnue contaminée qu'en 1883. Il est impossible de fournir une statistique même approximative et d'établir le pourcentage des cas de lèpre par rapport à population saine. On ignore, en effet, le nombre total des habitants, et les malades se soustraient par la fuite à tout essai d'examen médical. Il y a quelques années, on estimait le nombre des lépreux à 4 ou 5 000 sur une population de 25 000 aborigènes. Des renseignements datant de 1899, mais dont il est impossible de contrôler la valeur, portent le chiffre des lépreux à 2 000 sur 14 à 15 000 indigènes. Sur 460 habitants formant le total de la population des tribus de Ni, Poté, Azaren, Bouiron, examinés par MM. Auché et Birolleau, 20 furent reconnus lépreux. Sous l'action combinée de l'alcoolisme, de la tuberculose, de la syphilis et de la lèpre, la belle race canaque s'abâtardit et il est à prévoir qu'elle aura disparu dans un avenir prochain.

Aux îles **Loyalty**, dépendance administrative de la Nouvelle-Calédonie, sur 11 977 habitants répartis dans trois îles, il y a environ 190 lépreux, soit 16 $^0/_{00}$.

Le premier cas de lèpre observé sur un Européen a été signalé en 1888 par M. Forné.

Depuis cette époque, voici quelle a été la progression:

En 1888	1 cas	De 1888 à 1894 . .	37 cas
De 1888 à 1891 . . .	4 —	De 1888 à 1898 . .	132 cas.

Cette année même (1898), MM. Pierre et Auché avaient en observation 85 lépreux blancs, dont 8 seulement appartenaient à la statistique de 1894, c'était donc 77 nouveaux cas. Dans les dix premiers mois de l'année suivante, 45 cas n'ayant pas figuré sur les statistiques précédentes ont été relevés dont 30 parmi les forçats. M. Primet évalue à une trentaine le nombre des lépreux qu'on découvre chaque année dans la population blanche.

Ces chiffres sont certainement inférieurs à la réalité, car aucune mesure n'a été prise par l'administration pénitentiaire pour dénombrer les contaminés dans la population pénale. D'après M. Pierre, parmi les libérés des centres de la Foa, Ouamenie, Bouloupari, Farino, il y a de nombreux lépreux. La population européenne libre est très éprouvée. Mais la majorité des cas échappe à l'examen. „La moindre tentative d'enquête" dit M. Chédan, „fait découvrir un nombre relativement considérable de gens de race blanche contaminés".

Les ravages inquiétants que la lèpre exerce parmi les Européens, de la Nouvelle-Calédonie ne peuvent s'expliquer que par la contagion. Il serait impossible, dit M. Auché, de faire remonter à l'hérédité un seul cas de lèpre observé chez les blancs car tous les lépreux qui figurent dans la statistique, sauf quelques belges, italiens, espagnols ou arabes, sont nés en France. — Parmi les contaminés, quelques uns nient tout rapport intime avec les Canaques, mais la plupart les avouent. Le travail en commun, la cohabitation avec les indigènes, la nécessité de chercher un abri pour se coucher dans des cases abandonnées ont multiplié les chances de contagion.

La répartition de la lèpre parmi la population blanche de la

Nouvelle-Calédonie fournit un argument de grand poids en faveur de la contagion. Il n'existe pas une seule observation de femme lépreuse dans la population pénale. Cette immunité apparente ne s'explique-t-elle pas par ce fait, que la femme blanche (presque toujours mariée à un concessionnaire) n'entre pas en relation avec les Canaques?

Et chez les relégués, hommes ou femmes, au nombre des 4095, que leur régime a tenu éloigné jusqu'à présent de toute communication avec les indigènes, de tout contact avec le bagne, pas un seul cas de lèpre n'a été signalé. En revanche, les 10 504 condamnés au travaux forcés qui sont en rapports fréquents avec la population canaque décimée par la lèpre, fournissent au fléau un énorme contingent.

Les victimes que la lèpre fait dans la population libre sont des blancs vivant dans la brousse ou des fonctionnaires mobiles qui ont fréquenté des lépreux avérés ou qui ont eu à leur service des domestiques indigènes suspects. Par contre, toute la troupe (infanterie, artillerie, flotte), tous les colons-commerçants de Nouméa qui n'ont aucun contact avec les tribus contaminées sont restés indemnes. Donc en 10 ans (de 1888 à 1898), plus de 100 Européens, sans antécédents héréditaires, venant d'un pays non lépreux, ont contracté la lèpre en Nouvelle-Calédonie. Tous ces malades appartiennent à des catégories très diverses de la société, hommes libres, forçats en cours de peine ou libérés, qui forment environ les deux tiers de la population blanche de l'île. Or ces catégories n'ont entre elles qu'un seul point commun, celui d'être en rapport constant avec les indigènes. L'autre tiers qui comprend les relégués sans aucun commerce avec les Canaques reste sain. Seuls, ajoute M. Auché, une expérience de laboratoire suivie d'un résultat positif, un cas de transmission à genèse prouvée par l'observation, seraient des preuves de meilleur aloi en faveur de la contagion.

En face d'un tel péril, quelles mesures prophylactiques ont été prises?

De 1883 à 1889, un essai d'isolement est tenté à l'île Maré (groupe des Loyalti), à l'instigation des pasteurs protestants. En 1888, M. Forné soumet au conseil d'hygiène des voeux tendant à l'isolement des lépreux. Enfin, l'administration, après beaucoup d'hésitations, décide la création de lieux d'isolement à l'Ile-aux-Chèvres (Nouméa), au pic des Morts (Canala) et au cap Bocage (Houaïlou). Ces mesures, prises sans conviction, exécutées comme à regret, ne réussirent qu'à inspirer une fausse sécurité. Les léproseries établies dans chaque arrondissement, dit M. Primet, manquèrent totalement leur but. Loin de protéger la population saine, elles favorisèrent l'expansion de la lèpre par les malencontreuses allées et venues à travers l'île de quelques lépreux livrés par les tribus, en holocauste, à l'administration.

En 1892, devant l'inanité de ces efforts, le conseil général de la colonie vota des fonds pour l'aménagement d'une léproserie à l'île Art, appartenant au groupe des îles Belep situé à la pointe septentrionale de la grande île calédonienne. A l'avenir tous les malades internés dans les léproseries, sauf celle de l'île Maré (Loyalti) y seront réunis ainsi que les lépreux encore libres qu'on pourra découvrir. Les Européens seront eux-mêmes isolés, s'il y a lieu.

Les engagés, les immigrants Néo-Hébridais seront soigneusement examinés. M. Grall, médecin en chef de la colonie, prépare un projet de décret qui est signé le 22 septembre 1893.

En voici les dispositions principales:

Art. premier. — Seront admises à la léproserie située à Ouala (îles Belep) toutes les personnes malades de la lèpre qui en feront la demande.

Y seront envoyées d'office, après un temps d'observation au dépôt de l'île aux Chèvres ou dans les léproseries provisoires de l'intérieur de la colonie, toutes celles qui, étant reconnues atteintes de la lèpre, n'auraient aucun moyen de se soigner, tels que les vagabonds, les mendiants, les gens sans asile et sans ressources, ainsi que les indigènes des tribus.

Les transportés et relégués atteints de la lèpre seront internés aux îles Belep, dans un établissement spécial, créé par les soins et entretenu aux frais de l'administration pénitentiaire. Ils seront mis en observation à l'île Nou.

Art. 3. — Les personnes de condition aisée pourront être autorisées à se soigner à domicile et à leurs frais; elles devront s'isoler à une distance qui ne pourra être moindre de 4 kilomètres de Nouméa, 2 kilomètres de tout centre de population et 500 mètres de toute habitation.

Ces personnes devront utiliser sur place ou détruire leurs effets, mobilier, literie, ainsi que leurs animaux ou provisions de toute nature.

Leurs domestiques, gens de service etc. . . . devront s'astreindre aux précautions antiseptiques qui leur seront indiquées.

Art. 6. — L'état de maladie de la personne sera constaté par deux officiers du corps de santé des colonies ou, à défaut, par deux médecins civils dont les services seront requis.

Art. 10. — Il est loisible aux lépreux de faire cesser leur internement en quittant la colonie[1]).

En l'espace de quatre ans, dit M. Auché, cinq convois amenèrent des lépreux à la baie d'Ouala. En fait, les indigènes antérieurement isolés à l'île aux Chèvres, au pic des Morts et au cap Bocage furent à peu près les seuls qui entrèrent à les léproseries des Beleps. Aucun médécin ne fut attaché à l'établissement. Trois fois en cinq ans, un officier du corps de santé aborda l'île pendant quelques heures.

Quant à l'administration pénitentiaire, poursuit M. Auché, c'est seulement vers le milieu de l'année 1896 qu'elle se met en règle avec le décret de 1893. La léproserie, convenablement aménagée, est située sur la plage d'Aüe, un peu plus au nord que la baie d'Ouala et complètement séparée de cet établissement par un massif montagneux.

Les deux léproseries sont installées sur l'île Art, longue de 10 à 12 kilomètres, qui est parcourue par des vallées profondes paraissant

1) Ce décret ne contient aucune pénalité à l'égard des contrevenants. Aussi le Gouverneur de la Nlle. Calédonie m'écrit-il: „L'administration se trouve désarmée à l'égard des lépreux qui ne veulent pas soit entrer dans une léproserie, soit se retirer dans une habitation isolée. Il n'existe pas de sanctions effectives.“

très fertiles. Les baies d'Ouala et d'Aüe, où sont installées les léproseries, sont situées sur la côte Ouest.

Elles sont couvertes d'une végétation abondante. Les malades peuvent y trouver des terrains de culture. De petits ruisseaux, merveilleusement canalisés par les tribus qui peuplaient l'île autrefois, entretiennent une humidité constante.

L'isolement aurait pu être réalisé dans d'excellentes conditions, et pour la population saine et pour les lépreux, si l'on avait tenu la main à ce que les principes les plus élémentaires de la prophylaxie fussent rigoureusement observés. Il faut bien le reconnaître des fautes lourdes ont été commises qui ont rendu illusoire l'isolement aux îles Belep malgré les sacrifices consentis par la colonie. Les tribus canaques qui durent évacuer l'archipel des Belep avant la fondation des léproseries, et qui reçurent en compensation des terres sur la grande Ile dans la région de Balade, ne considèrent jamais comme périmés leurs droits sur leurs anciens biens. Ils se sont empressés de venir les réoccuper. Les lépreux vendent leurs produits (volailles, oeufs, coprah, etc.) à des commercants voisins qui viennent prendre livraison avec des embarcations à voile. Les malades isolés dans l'île Art sont dans un état de détresse extrême par suite du manque d'hygiène, de soins médicaux, de viande fraîche et même de nourriture. Les villages sont en état de guerre constante, car la misère n'a pas rapproché ces malheureux.

Aucun médecin n'est attaché à l'établissement; au mépris de l'article 6 du décret de 1893, des indigènes sont envoyés à l'île Art sur l'ordre d'administrateurs, de gendarmes ou de chefs de tribus. Peu à peu, la léproserie a été détournée de sa destination primitive, dit M. Chédan, et ce n'est plus maintenant qu'une tribu ordinaire contenant, peut-être, un peu plus de lépreux que les autres du reste de l'île.

Peu de temps après, le crédit affecté à l'entretien de la léproserie centrale des Beleps est supprimé. Les Canaques qui y étaient internés sont débarqués sur plusieurs points de l'île, à proximité de leurs tribus, qui sont chargées de les isoler. Mais ces lazarets indigènes n'ont qu'une „barrière fictive et morale". Ainsi donc: pas d'isolement effectif; — pas d'examen médical pour opérer le triage des lépreux qui abondent dans les tribus, pas de médecin pour choisir l'emplacement des léproseries et veiller à leur d'amenagement, et pendant qu'on tergiverse le fléau grandissant menace d'annéantir la population toute entière![1])

Quant aux lépreux européens, ils ont été ramenés à l'Ile-aux-Chèvres située derrière la presqu'île Ducos, dans la baie de la Dumbéa, à une heure environ de Nouméa. Leur installation laisse beaucoup à désirer.

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1) Depuis la rédaction de ce chapitre, j'ai reçu de M. le Gouverneur de la Nlle. Calédonie l'état numérique des lépreux isolés; ils sont au normal des 523 savoir:

Léproserie de l'Ile-aux-Chèvres (Européens)	32
Léprosie pénitentiaire	75
Léproseries indigènes	309
Iles des Pins et Loyalt	107

L'administration pénitentiaire a maintenu la léproserie des condamnés et libérés à la baie d'Auë dans l'île Art. Mais cet établissement où sont internés 35 lépreux ne peut en contenir davantage. Aussi un nombre à peu près égal de condamnés lépreux ont été dirigés sur l'ancienne léproserie de l'île Nou.

M. Auché, à qui j'emprunte l'étude qui précède propose de créer une léproserie unique, à la presqu'île Ducos, dans les bâtiments que l'administration penitentiaire n'utilise plus par suite du ralentissement de la transportation en Nouvelle-Calédonie. Chaque catégorie de lépreux, européens libres, relégués et condamnés, indigènes, occuperait un quartier spécial. L'établissement serait dirigé par un médecin rompu aux études bactériologiques qui serait soustrait au roulement général des médecins des Colonies, et aurait dans ses attributions l'inspection sanitaire des tribus, des pénitenciers et des écoles.

M. Primet conseille de revenir à l'ancien système celui d'une léproserie centrale située dans l'île Art. Elle comprendrait deux quartiers distincts, l'un pour les Canaques, l'autre pour les Européens de l'élément pénal.

Quelques léproseries partielles pourraient être maintenues, à titre de stations sanitaires où les suspects seraient mis en observation avant qu'il soit statué sur leur sort.

Créer une léproserie, ne consiste pas à parquer des malheureux sur le même point. Il faut leur assurer un certain confort. Il faut leur permettre de se grouper suivant leur origine, leurs affinités et leurs moeurs, il faut leur distribuer des terres qu'ils transformeront en colonie agricole, il faut enfin soulager leurs souffrances en leur donnant des soins médicaux.

Outre la léproserie centrale, M. Primet juge qu'il serait utile d'établir, à proximité de Nouméa, une léproserie-hôpital pour les lépreux de condition libre. Il fait remarquer, avec juste raison suivant moi, combien l'article 3 du décet de 1893 qui autorise, sous certaines conditions, les lépreux à se soigner à domicile prête à la critique. Il est à craindre que ces lépreux ne créent de nombreux foyers dans la banlieue de Nouméa. Il serait donc bien préférable de les grouper sur un espace isolé, tel que la presqu'île Saint-Marie, où ils pourraient posséder chacun leur maison particulière et leur jardin.

Pour compléter le plan de défense contre la lèpre en Nouvelle-Calédonie, M. Primet réclame les mesures suivantes:

Poursuivre sans relâche l'enquête sur la lèpre en inspectant les tribus;

Visiter les écoles indigènes, n'y recevoir que des enfants reconnus sains;

Soumettre à un examen médical tout individu mis en état d'arrestation;

N'admettre à un emploi quelconque que des indigènes munis d'un certificat sanitaire renouvelable tous les six mois.

Surveiller avec vigilance les immigrants, néo-hébridais, annamites, chinois, javanais, japonais qui sont disséminés, au nombre de 3000 dans les centres miniers, industriels et agricoles et dans les principales agglomérations urbaines, à Nouméa en particulier, et leur imposer une visite médicale deux fois par an;

Exiger pour qu'un contrat d'engagement ou de rangagement soit valable qu'il soit accompagné d'un certificat attestant que l'engagé n'est pas lépreux[1];

Interdire toute relation entre canaques, condamnés ou relégués;

Renouveler la visite sanitaire des prisonniers de toutes catégories deux fois par an;

N'accorder la libération, l'envoi en concession ou l'obtention de la rélégation individuelle d'un condamné qu'après s'être assuré qu'il est indemne de lèpre.

Toutes ces mesures sont à prendre en considération mais l'expérience seule peut indiquer celles qui sont pratiquement réalisables. Quelque soit le projet qu'ón adopte, il faut le suivre avec conviction et continuité. L'ère des atermoiements ne saurait durer sans compromettre à tout jamais l'avenir d'une des rares colonies françaises où le blanc peut vivre, travailler et multiplier comme dans la mère-patrie.

Chapitre 9. — Etablissements de l'Océanie.

Aux îles **Marquises**[2]) le fléau a pris des proportions effrayantes. Un quinzième de la population est atteinte de lèpre avérée, dit M. Buisson, et ce chiffre est au-dessous de la vérité. Cette maladie est avec la tuberculose, la syphilis, la variole et l'alcoolisme, une des causes d'extermination de la belle race maorie. En 1860, il y avait dans l'archipel 15 à 20 000 indigènes; aujourd'hui on n'en compte plus que 3 317. Des vallées entières sont dépeuplées. Le chiffre des naissances est bien inférieur à celui des décès.

Les habitants n'ont aucune répulsion pour le lépreux qui continue, même à une période avancée, à vivre dans la famille et à plonger dans la koka (plat de bois) ses mains ulcérées et mutilées. Le lépreux trouve facilement à prende femme et M. Buisson cite plusieurs cas de lèpre conjugale.

La lèpre, qui porte le nom de Kovi, existait certainement aux Marquises avant l'arrivée des Chinois. Mais, de même qu'à Taïti, la maladie ne semblait connue que sous sa forme anesthésique et les indigènes attribuent aux Chinois l'introduction de la lèpre tubéreuse.

Beaucoup d'Européens sont atteints; chez eux, c'est la forme tégumentaire et floride qui prédomine, tandis que la forme trophoneurotique est plus commune chez les naturels. M. Buisson cite plusieurs cas de contagion. Deux enfants de race blanche qui jouaient habituellement avec un lépreux ont contracté la maladie. Un européen, marié à une canaque dont la famille comptait un lépreux, a eu de nombreux enfants;

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1) Un arrêté du 17 Novembre 1896 décide que tout engagiste est tenu de faire visiter par un médecin les immigrants et indigènes qui sont à son service. Ce certificat sanitaire doit être renouvelé tous les six mois. Tout contrevenant, dit l'arrêté, sera passible d'une amenade de 10 à 15 francs; en cas de récidive d'une amende de 15 à 100 francs et d'un emprisonnement de 1 à 5 jours. — Cette mesure n'est pas appliquée, et d'ailleurs l'entrée de la Colonie n'est pas interdite aux lépreux.

2) Buisson, Ann. d'Hyg. et de Méd. coloniales. Oct.-Dec. 1903. p. 549.

trois de ses filles ont été atteintes et lui-même a fini par être contaminé.

D'après M. Buisson, le système des léproseries par districts peut rendre de grands services aux Marquises, pourvu que la surveillance soit confiée à des gendarmes. La léproserie centrale créée à Puaman par M. Marestang était certainement la solution la meilleure. Malheureusement elle a été supprimée, après quelques mois d'existence, en raison des dépenses qu'elle entraînait. Du reste, les malades n'y entraient que contraints et forcés, et depuis lors ils évitent autant que possible de s'adresser au médecin.

Si l'on estime que le système des léproseries isolées fait courir trop de dangers et qu'une léproserie unique coûte trop cher, ne pourrait-on pas, dit M. Buisson, affecter une vallée entière aux lépreux de ces îles où le cocotier et l'arbre à pain poussent à foison dans de vastes solitudes?

La lèpre fait d'énormes ravages dans les **îles de la Société**: Taïti, Mooréa etc. —

Chapitre 10. — **Etablissements français de l'Inde.**

La lèpre est fréquente dans ces territoires qui font enclave dans l'Inde anglaise. A Pondichéry, 116 cas ont été traités en 1901, et ce chiffre est minime en comparaison des lépreux qui sillonnent les villages de l'Etablissement[1]).

Chapitre 11. — **La lèpre en Indo-Chine**[2]).

Projet de réglementation concernant sa prophylaxie.

L'endémie lépreuse sévit dans toutes les parties de l'Union indo-chinoise. Elle se cantonne de préférence dans les régions surpeuplées qui avoisinent l'estuaire des grands fleuves. Elle occupe deux foyers principaux. Le méridional couvre toute la superficie de la Cochinchine. Le foyer septentrional ou tonkinois a pour limites le delta du fleuve Rouge. Le long de la côte d'Annam, sur l'étroite bande fertile comprise entre la ligne de partage des eaux et le littoral, la population est nombreuse et la lèpre très commune.

Au Cambodge, région basse et marécageuse, en majeure partie couverte de forêts et fort peu peuplée, la lèpre ne fait pas beaucoup de victimes si l'on excepte les centres importants[3]). Dans le Laos français, où 800 000 hommes tout au plus sont disseminés sur un immense territoire, la lèpre ne forme que des îlots insignifiants.

Le système orographique du Yunnan, province chinoise située dans la zone d'influence française, n'est pas compatible avec la formation de grandes agglomérations humaines. La population est donc peu fournie, et comme elle est distribuée par îlots entre lesquels les

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1) Kermorgant, La lèpre dans les Colonies françaises au cours de l'année 1901. Bull. de l'Acad. de Méd. 3. Mars 1903.

2) Jeanselme, E. Etude sur la lèpre dans la presqu'île indo-chinoise et au Yunnan. Presse médicale, 1900.

3) Angier, La lèpre au Cambodje. Ann. d'Hyg. et de Méd. coloniales.

moyens de communications sont difficiles, il n'y a pas au Yunnan un foyer cohérent de lèpre, bien que cette maladie y soit partout répandue.

D'après l'enquête que j'ai faite sur lieux, j'estime que le nombre des lépreux disséminés dans l'Indo-Chine française est de 12 à 15000.

Or, même dans les grands centres européens, les précautions les plus élémentaires pour se prémunir contre la contagion sont négligées. Je pourrais citer 4 Européens qui ont contracté la lèpre dans l'Indo-Chine française. Et si des mesures énergiques ne sont pas prises, nul doute que la lèpre ne fasse tôt ou tard, parmi la population blanche de cette colonie, autant de ravages qu'en Nouvelle-Calédonie. Sous la domination annamite, les lépreux étaient groupés dans des villages. Mais, depuis la conquête, tous ceux qui ne sont pas indigents se sont mélangés avec la population saine.

Un village de lépreux, tel que celui de Ninh Binh par exemple, est un vaste rectangle limité seulement par une levée de terre. Les lépreux parqués dans cet espace construisent de misérables paillottes où ils vivent avec leurs familles, de sorte que la population saine égale au moins celle des lépreux.

Comme l'allocation accordée par le Protectorat est notoirement insuffisante, les lépreux rayonnent dans les localités environnantes pour aller mendier dans les marchés. Ceux qui sont encore en état de travailler, s'engagent au service des paysans voisins pour faire les semailles et la moisson.

Au lieu d'être des foyers d'extinction de la lèpre, ces villages sont donc en réalité des foyers de propagation.

Par suite de l'accroissement rapide de la population, le village des lépreux de Hanoï formait, il y a quelques années, une véritable enclave dans la ville même. Ce village était adossé à l'hôpital et les logements des infirmiers européens et indigènes étaient contigus aux cases des lépreux sans qu'il y eût aucune démarcation.

Comme le terrain sur lequel s'étaient établis ces lépreux avait acquis une valeur considérable, ceux-ci furent en partie expropriés ou expulsés, et l'on construit actuellement sur ce sol imprégné de sanie lépreuse des habitations pour les colons européens.

Il faut donc, sans hésitation ni retard, appliquer les réformes les plus urgentes.

Mais pour qu'elles soient efficaces, elles doivent être uniformes et coordonnées sur tout le territoire de nos possessions indo-chinoises. Des réglementations partielles et locales n'aboutiraient qu'au déplacement des lépreux fuyant devant les mesures de rigueur, grâce à la complicité de leurs familles et des autorités indigènes.

A—A l'exemple des colonies anglaises, il faut interdire aux lépreux avérés l'exercice de certaines professions, entre autres celles de:

Boulanger, boucher, laitier, cuisinier, porteur d'eau, ou tout métier dans lequel la personne employée manie des aliments, des boissons, des médicaments, du tabac ou de l'opium; — Blanchisseur, tailleurs, ou

tout métier dans lequel la personne employée manufacture ou manie des vêtements;

Barbier, ou tout métier similaire dans lequel la personne employée vient en contact avec d'autres personnes, serviteur, médecin, nourrice, sage-femme, infirmier, pharmacien, instituteur, conducteur de voiture de louage ou de jinrikisha (vulgairement appelée pousse-pousse en Indo-Chine), prostituée.

Il faut en outre interdire aux lépreux avérés de:

Se baigner, laver des vêtements ou puiser de l'eau à tout puits public ou réservoir qui n'est pas spécialement destiné à l'usage des lépreux par les règlements municipaux;

Monter dans les voitures publiques, loger dans un hôtel garni. Et ce, sous peine d'une amende dont le montant, et d'un emprisonnement dont la durée seront fixées par une décision du Gouvernement.

Les mêmes peines seront encourues par toute personne qui emploie, en connaissance de causes un lépreux à l'un des métiers ci-dessus désignés.

B. — L'immigration jaune doit être surveillée, en particulier celle des Chinois qui viennent en grand nombre du Quang Toung et du Fokien, provinces où la lèpre est endémique.

Ces immigrants sont tenus, d'après les règlements en vigueur, de se faire inscrire dès leur arrivée dans la colonie pour obtenir une carte de séjour, et de se présenter au bureau anthropométrique.

Il est donc facile de leur faire subir une visite médicale et d'éliminer les lépreux. Ceux-ci seraient immédiatement réembarqués aux frais du capitaine ou patron du navire qui les aurait débarqués.

Le médecin commis à l'examen des immigrants devra justifier d'une connaissance suffisante de la lèpre. Il sera soustrait au roulement, afin qu'il acquière une compétence spéciale et qu'en cas de négligence les responsabilités puissent être établies.

Les instruments nécessaires pour faire un examen micrographique seront mis à la disposition de ce médecin.

C. — Les indications ci-dessus énoncées peuvent être remplies sans entraîner des frais trop considérables.

Les mesures suivantes sont plus dispendieuses. Elles ne sont pourtant pas moins nécessaires, car il y va de l'avenir de la colonie.

En principe, tout lépreux doit être isolé.

La grande difficulté qui s'oppose à l'application de cette mesure, c'est que beaucoup de familles ne consentent pas à se séparer de leurs parents ou de leurs enfants atteints de la lèpre. Delà, parmi les lépreux une distinction fondamentale:

1. les uns peuvent pourvoir eux-mêmes à leurs besoins ou être entretenus par ceux de leurs parents qui en ont la charge légale;

2. les autres sont dénués de moyens d'existence et n'ont pas de parents en état de leur venir en aide.

Les premiers seront internés, à leurs frais ou aux frais de ceux qui en ont la charge légale, dans des Léproseries terrestres, situées dans les points de la colonie où l'endémie lépreux est le plus considérable.

Chaque fois que cela sera possible, ces léproseries seront établies dans une île inhabitée du Mékong ou du Fleuve Rouge, où les lépreux pourront se livrer à la culture et construire des villages.

A défaut de léproseries insulaires, les lépreux seront groupés en colonies, toujours distantes des agglomérations urbaines, et entourées d'une clôture effective.

En aucun cas, il ne sera permis de construire une habitation quelconque dans un rayon de 200 mètres autour de la léproserie.

Chaque établissement comprendra des pavillons isolés pour les deux sexes, une salle d'observation pour les suspects, une infirmerie et une buanderie. Le cimetière des lépreux sera compris dans l'enceinte de la léproserie.

Un quartier à part sera reservé à la détention des prisonniers lépreux de la région.

Les enfants qui naîtront dans l'établissement seront immédiatement séparés de leur mère. Ils seront éléves dans un Orphelinat annexé à la léproserie, et soumis à l'allaitement artificiel. Une observation prolongée prouve, en effet, que jamais un enfant né naît lépreux.

Les permissions de sortie accordées aux lépreux, les visites des parents à la léproserie, les peines disciplinaires en cas d'insubordination grave ou d'évasion, le régime alimentaire et l'entretien des lépreux feront l'objet de règlements particuliers. La direction de la léproserie pourra être confiée à un missionnaire assisté de religieuses pour panser et soigner les malades.

Le médecin des colonies du poste le plus voisin sera chargé de visiter l'établissement au moins deux fois par mois.

Tout lépreux vagabond ou indigent, dont la famille n'est pas en état de subvenir à ses besoins, devra être interné dans une léproserie maritime.

Cet établissement doit remplir les conditions suivantes:

1. Etre situé dans une île assez distante des côtes pour que toute évasion soit impossible;
2. Etre susceptible de culture;
3. Etre abondamment pourvue d'eau: les ablutions fréquentes étant la base du traitement hygiénique de la lèpre;
4. Etre peu peuplé: l'île choisie devant être évacuée par la population saine.

Les lépreux encore valides, internés dans une léproserie maritime recevront des terres sur lesquelles ils pourront construire des villages à leur guise. Ils auront tous les privilèges de la liberté, à la condition expresse qu'ils ne fassent aucune tentative pour sortir de l'île.

Les lépreux dont les mutilations sont trop avancées pour permettre un travail quelconque seront réunis dans des pavillons de construction légère et peu coûteuse.

Les prisonniers lépreux seront détenus dans un quartier à part.

Une infirmerie, une pharmacie avec dispensaire pour la délivrance des médicaments, une buanderie complèteront l'établissement.

Tout lépreux décédé devra être enterré dans l'île. Aucun corps ne pourra être transporté sur la terre ferme.

Aucun produit de culture, aucun objet fabriqué ne pourra être exporté de l'île ou des léproseries terrestres.

Un bateau exclusivement affecté à l'usage des lépreux, et remorqué par une chaloupe à vapeur, fera le service de la léproserie et effectuera le transport des lépreux.

L'administration de la léproserie maritime pourra être confiée à un missionnaire assisté de soeurs.

Un médecin soustrait au roulement, résidera dans l'île; il procèdera à l'examen de tous les lépreux dès leur arrivée.

Un laboratoire de bactériologie sera mis à sa disposition.

Il suffirait de deux léproseries maritimes pour toute la colonie: l'une située dans l'archipel de Poulo Condor ou toute autre île de ces parages, sur laquelle seraient dirigés les lépreux de la Cochinchine, du Cambodge, du Bas-Laos et de la côte d'Annam jusqu'à Hué; l'autre dans la baie d'Along ou les îles côtières du Haut-Tonkin, qui recevrait les lépreux du Haut-Laos, du Tonkin et de la côte d'Annam depuis Hué.

Les autorités locales seront tenues, et ce sous peine d'amende ou d'emprisonnement, de faire conduire aux léproseries terrestres les lépreux trouvés sur leur territoire. Elles devront en outre déclarer au directeur si le lépreux est indigent ou s'il peut être entretenu à ses frais ou à ceux de ses parents qui en ont la charge légale. Ces suspects seront réunis dans un pavillon spécial, jusqu'à ce que le médecin chargé de la léproserie les aient examinés. S'ils sont reconnus sains, ils seront immédiatement mis en liberté. S'ils sont reconnus lépreux, ils seront, sur la délivrance d'un certificat par le médecin, soit immatriculés à la léproserie terrestre, soit dirigés sur une léproserie maritime.

Tout lépreux pourra se présenter spontanément à l'examen du médecin de la léproserie.

Aucun individu sain, ou atteint d'une maladie autre que la lèpre, ne pourra être admis dans une léproserie.

La série des mesures ci-dessus indiquées sera complétée ainsi qu'il suit:

Interdire le mariage à tout indigène reconnu lépreux;

Surveiller les foires, marchés et tous autres lieux de rassemblement;

Recommander aux médecins des postes médicaux et aux médecins en tournée de vaccine de visiter périodiquement et à des époques indéterminées les élèves des écoles, les prisonniers, les miliciens, les agents de la police indigène et les prostituées. Ces médecins dresseront, s'il y a lieu, des certificats, et les autorités locales devront soumettre à l'examen de ces médecins tout indigène soupçonné d'être atteint de la lèpre;

Défendre de pratiquer la variolisation et la vaccination de bras à bras;

Porter à la connaissance du public, par voie d'affiches, rédigées en français et en langue vulgaire, les signes apparents de la lèpre, les dangers de la contagion et les moyens de s'en prémunir.

Tout médecin des colonies devra faire un stage dans l'une des

léproserie maritimes, pour s'exercer au diagnostic clinique et bactériologique de la lèpre.

Les léproseries terrestres et maritimes devront être visitées, au moins deux fois par an, par un fonctionnaire délégué par le Gouverneur (résident de la province etc.).

Les frais de transport et d'entretien des lépreux dans les léproseries maritimes seront à la charge des budjets municipaux et locaux.

Les frais d'installation des léproseries maritimes (personnel médical et administratif, laboratoire, pharmacie etc.), seront supportés par le budget général de la colonie.

Près de cinq ans se sont écoulés depuis que ce chapitre sur la lèpre en Indo-Chine a été écrit. La situation reste à peu près la même. Un arrêté du 1er Août 1903 décide qu'une léproserie, pour la Cochinchine, sera créée dans l'île de Culao-Rong, sur le Mékong, dans la province de Mytho. Y seront internés d'office tous lépreux circulant sur la voie publique; pourront en outre y être admis, sur leur demande, tous les autres lépreux.

Au Tonkin, une commission a été instituée à l'effet de rechercher un emplacement propice à la fondation d'une léproserie vers laquelle seraient dirigés les mendiants lépreux du Delta dont le nombre est évalué à 1500 environ. Il est question de les isoler, soit dans une île de la baie d'Along, soit dans une presqu'île située près de Quang Yen.

Le village de Mui, qui a remplacé l'ancien village de lépreux situé à Hanoï même, est distant de cette ville de dix kilomètres environ[1]. Il est placé sous la direction effective de la Mission catholique et un prêtre indigène y réside en permanence. Quatre chefs annamites sont préposés à la police. La superficie du village, habitations comprises, n'excède pas 25 maos (le mao est un carré ayant 72 mètres de côté). Aussi les rizières cultivées par les lépreux étant insuffisantes pour les nourrir, le budjet procincial leur alloue une somme mensuelle de 400 piastres. Les naissances et les décès (16 en moyenne par an) s'équilibrent à peu près.

Dans cette agglomération, des fautes nombreuses contre la prophylaxie sont accumulées:

a) Sur une population de 400 indigènes, 180 seulement sont des lépreux confirmés. Les autres sont sains ou considérés comme tels. Ces derniers ont le droit d'aller travailler au dehors. Les malades seuls sont séquestrés sous la garde d'un corps de miliciens. Mais, comment au milieu des allées et venues incessantes une surveillance réellement utile peut-elle s'exercer?

b) Les habitants soi-disant sains, qui jouissent d'une liberté entière, sont certainement des agents de dissémination de la lèpre. Certaines femmes ou filles, qui ont passé toute leur enfance en plein foyer lépreux vont vivre ensuite avec des Européens.

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1) Les renseignements qui suivent m'ont été obligeamment fournis par M. Degorce, professeur à l'Ecole de Médecine indigène de Hanoï.

c. Les habitants des communes voisines ont libre accès au village de Mui. Des restaurateurs ambulants y viennent, chaque jour, pour vendre du riz et des potages. Delà, ils se rendent dans d'autres villages, et les mêmes bols, les mêmes baguettes servent aux clients non lépreux.

d. A l'intérieur du village de Mui, tout contribue favoriser la contagion. Les cases des lépreux alternent avec celles des individus sains, afin que les infirmes puissent être assistés par les valides. La cohabitation est autorisée et les enfants sont nombreux; c'est généralement vers l'âge de 10 à 15 ans qu'apparaissent les premiers signes de la lèpre.

En terminant ce chapitre, j'exprime le désir que l'on avise sur l'heure. Aujourd'hui, dans cette colonie d'Indo-Chine encore jeune, les métis sont relativement peu nombreux et ils ne sont pas acceptés dans les familles. Mais quand la fusion des sangs sera accomplie, il faudra s'attendre aux mêmes résistances qui désarment les autorités dans les vieilles colonies, telles que la Guyane, les Antilles et la Réunion.

Chapitre 12. **Du Rôle respectif de la Métropole et de la Colonie dans la lutte contre la lèpre.**

Jusqu'à ce jour, la France a laissé le fléau décimer ses possessions lointaines. Son intervention tardive (1898) s'est bornée à faire ajouter la lèpre à la liste des maladies dont la déclaration est obligatoire aux Colonies. Or, la métropole, pour des raisons multiples, a le droit et le devoir d'exiger que dans toutes ses Colonies la lèpre soit pourchassée et que ses ravages soient contenus dans les limites du possible. Ce faisant elle témoignera, d'une part, de sa sollicitude pour ses nationaux dont elle doit protéger la vie aussi bien que les intérêts matériels, elle effacera d'autre part, le mauvais renom qui s'attache aux pays à lèpre et entrave l'essor de la colonisation, enfin elle pourvoira à sa propre sécurité, car le retour dans la mère-patrie de citoyens contaminés constitue, pour elle-même, un véritable danger.

Les principes intangibles, que la métropole doit imposer indistinctement à toutes ses possessions sont les suivants:

1. Interdire l'entrée de la Colonie aux immigrants lépreux;
2. Isoler les malades atteints de lèpre ouverte et virulente;
3. Interdire aux lépreux, laissés libres, l'exercice de certaines professions.

Il appartient à chaque colonie de rechercher les voies et moyens dont elle dispose pour s'appliquer à elle-même ces principes généraux, en tenant compte des circonstances de temps, de lieu et de race.

La tâche est loin d'être aisée. Elle pourrait être confiée à une Commission permanente dont le directeur du service de santé, le directeur des douanes et régies représentant le fisc, des notables blancs et indigènes représentant la population, seraient membres de droit. Cette Commission, s'inspirant des principes généraux sus-énoncés, rédigerait après enquête un projet de législation contre la lèpre, puis

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elle en surveillerait l'exécution et, au besoin, y apporterait les modifications jugées nécessaires.

Les questions qui intéressent l'état sanitaire d'une colonie, telles que la lutte contre la lèpre, devraient être soustraites aux fluctuations de la politique. Si les Corps élus peuvent refuser les crédits demandés, ils n'est pas impossible qu'ils emploient cette voie détournée pour faire avorter les réformes. Il importe donc que l'Administration, en cas de conflit, puisse passer outre. Cette prétention n'est pas exorbitante, car, en France même, au cas où un Conseil municipal refuse rait de voter la somme nécessaire pour assurer l'exécution de la loi sur la Santé Publique, le Préfet inscrirait d'office au budjet les crédits supprimés.

Algerien.

Bericht

von

L. Raynaud in Algier.

I. Statistique.

En 1897, nos avons, avec Monsieur le Professeur Gemy, dont le nom doit rester attaché à celui de la lèpre en Algérie, rapporté 58 observations de Lèpre dans notre colonie Nord-Africaine; les cas constatés se répartissaient sur 27 Indigènes, Juifs et Musulmans, et 31 Européens, dont 24 Espagnols provenant de la région de Valence et d'Alicante.

Depuis cette époque j'ai pu réunir 34 cas nouveaux[1]) représentant:

Espagnols	24
Musulmans	8
Israélites	2
	34

Ce qui, avec les cas antérieurs, représente un total de 92 malades. Au point de vue du sexe ces cas se distinguent en:

	Hommes	Femmes	Total
Espagnols	17	7	24
Musulmans	8	—	8
Israélites	1	1	2
Total . .	26	8	34

L'âge des malades, au moment où ils ont été vus pour la première fois, est indiqué par le tableau suivant:

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1) Dans ce nombre sont compris 3 individus dont M. Le Professeur Brault a publié l'observation (An. de Dermat.); 5 observations avaient été recueuillies par mon regretté maitre M. Le Professeur Gemy; 3 sont communs à Gémy et à moi, 10 observations me sont personnelles, les autres m'ont été communiquées par des confrères de l'Algérie, notamment par M. le Docteur Legrain (de Bougie).

1 Cas entre 10 et 20 ans
6 id. id. 20 et 30 id.
5 id. id. 30 et 40 id.
6 id. id. 40 et 50 id.
2 id. id. 50 et 60 id.
2 id. id. 60 et 65 id.

Dans douze cas l'âge n'est pas déterminé exactement (indigènes notamment) et peut être estimé entre 25 et 35 ans.

On remarquera que c'est entre 20 et 50 que se constate le plus grand nombre de malades, et que beaucoup ont pu atteindre un âge avancé: 60 et 65 ans.

La forme de l'affection est ci-dessous représentée:

	Espagnols	Musulmans	Juifs	Total
Tuberculeuse .	16	1	1	18
Nerveuse . .	6	5	1	12
Mixte	2	2	—	4
Total . .	24	8	2	34

Au point de vue géographique les malades ont été observés dans les localités suivantes:

I. Alger et Faubourgs . . . 16
Département d'Alger . . . 10
26

sur ces 26 cas, on ne compte que 3 Kabyles et 2 Israélites; les 21 autres sont Espagnols.

II. Département de Constantine . . . 2 Cas
tous Indigènes: 1 Arabe et 4 Kabyles.
III. Département d'Oran . . . . . . 3 Cas.
Espagnols:

Considérations Générales.

La Lèpre est peu répandue chez les Indigènes; elle ne semble pas, jusqu'à présent du moins, s'étendre, puisque sur 92 cas, en comprenant les observations antérieures à 1897, nous n'en relevons que 16 propres à nos sujets. Il n'en est pas de même chez les Espagnols: alors que jusqu'en 1897 les cas observés étaient d'importation récente, et que les malades avaient contracté leur affection dans leur pays d'origine (environs d'Alicante), nous avons pu compter depuis un certain nombre d'individus qui paraissent avoir pris le mal dans la Colonie.

Sur 24 Espagnols:

6 sont nés en Algérie et n'ont jamais quitté la colonie.
9 sont nés en Espagne (Alicante) mais, au moment où ils ont eu les premiers symptômes de leur mal, ils avaient quitté leur pays pour s'etablir en Algérie, depuis 4, 5, 6, 7, 20 (2 fois), 25 (2 fois), 30 ans.
7 ont eu les premières atteintes du mal en Espagne.
2 ne donnent aucun renseignement.

Les 8 Musulmans sont nés dans le pays; des 2 Israélites, une femme est née à Alger, l'autre né en Alsace, a pris son mal après un séjour de dix ans dans notre ville, où il habitait une maison occupée par une lépreuse espagnole.

Il ne me paraît pas qu'on puisse encore attribuer à la Lèpre une incubation de 25 à 30 ans; si donc on écarte, comme ayant été contaminés dans leur pays les malades qui avaient quitté l'Espagne depuis quatre à sept ans, malades qui avaient pu présenter des lésions très atténuées de Lèpre avant d'attirer l'attention, on voudra bien admettre que 5 au moins sur 9 des Espagnols nés en Espagne ont contracté le germe en Algérie. De même on ne peut nier que les 6 individus qui sont nés ici, de parents Espagnols, n'aient trouvé dans la colonie un foyer récemment créé.

Notons que dans 2 cas (Observations de Glorget et Brault — et Observation du Docteur Payan) les malades étaient des filles de lépreux avérés, soignés antérieurement par nous. — Nous avons de plus observé récemment dans les environs d'Alger une famille dont le père, âgé de 56 ans a contracté en Espagne à 17 ans une lèpre nasale, demeurée très atténuée depuis, et dont les deux fils (nés en Algérie) présentent des lépromes très accussés avec anesthésie, nodosités du cubital, etc.

De ces constatations il résulte donc que, à côté de la lèpre indigène, à manifestation trophonévrotique et par conséquent peu contagieuse et rare, existe un foyer européen, constitué par des apports répétés d'un foyer très anciennement connu dans la province d'Alicante (Espagne). Aux premiers cas relevés par nous chez des individus émigrés d'Ibérie s'ajoutent les cas de malades qui ont contracté leur affection en Algérie.

Le danger est d'autant plus grand que l'émigration espagnole représente environ les deux tiers du mouvement des étrangers (18420 sur 32 859) et que les gens d'Alicante et de Valence occupent des professions qui les mettent constamment et intimement en rapport avec des familles européennes (domestiques, lessiveuses, nourrices, etc.). Nous connaissons deux laitiers lépreux, et un marchand d'arachides qui a son étalage devant le square le plus fréquenté par les enfants de la ville d'Alger.

Il n'y a actuellement aucun Asile spécial, aucun service d'isolement dans les hôpitaux; les lépreux sont dans des salles communes; il est vrai de dire que jusqu'à présent, à notre connaissance du moins, aucun cas de contagion ne s'est déclaré dans les établissements hospitaliers.

II. Mesures prises par le Gouvernement Général de l'Algérie.

Avant même la Conférence internationale de Berlin le Gouvernement Général de l'Algérie, sur notre initiative, adressait le 17 Juillet 1897 une circulaire aux Directeurs de la Santé dans les ports pour faire surveiller les arrivées d'Espagne.

Après la conférence, le Comité Consultatif de France, saisi de

notre Statistique, et sur rapport de M. Le Professeur Proust, décidait que la Lèpre prendrait rang parmi les maladies à déclaration obligatoire. Le Gouvernement Général faisait connaître „qu'il y aurait lieu d'inviter les malades, dénués de ressources et présentant des lésions suppurantes, à se rendre à l'hôpital où ils seront isolés et maintenus jusqu'à la guérison des plaies pouvant devenir des agents de transmission. Les malades non hospitalisés seront soumis à une surveillance spéciale, qu'il appartiendra (à l'Administration préfectorale) de déterminer.“ 2 Juin 1898.

Afin cependant d'unifier les mesures propres à arrêter le développement de l'affection en Algérie, M. Lépine, Gouverneur Général, nomma le 21 Mars 1898 une commission composée de trois chefs de service de l'Assistance et de l'Hygiène au Gouvernement Général, et des Docteurs Gemy et Raynaud.

Cette commission proposa un certain nombre de mesures, dont quelques unes, d'application facile, furent mises en éxécution par le fait même des réglements généraux sur l'Assistance et l'Hygiène; les autres nécessitant de pourparlers diplomatiques, des arrêtés discutables au point de vue strictement légal, des crédits nouveaux à faire inscrire au budget, se trouvèrent renvoyées à une date indéterminée par des évènements autrement graves et d'ordre politique, qui occupèrent toute l'attention des pouvoirs publics, nous voulons parler de troubles antisémitiques.

Pendant ce temps, la Lèpre faisait des progrès continuels; notre statistique, toute personelle, obtenue sans le concours du Gouvernement, aidée de quelques indications de confrères amis, porte presque uniquement sur nos clients d'Alger; elle est loin de représenter le chiffre des cas existant en Algérie. Alors que depuis 1897 nous avons pu relever 34 cas nouveaux, des recherches plus minutieuses, fait avec l'appui de l'Administration, feraient découvrir trois fois autant de malades dans les deux autres Départements et plus spécialement dans celui d'Oran, où émigrent davantage les Espagnols. Dans le Département de Constantine et en Tunisie on trouverait des lépreux Maltais et Siciliens.

A la suite d'une communication faite par nous au Congrès Colonial[1]) (de Janvier 1903) et à la Société de Médecine d'Alger (Juin 1903) sur le danger lépreux dans l'Afrique du Nord, le Gouvernement Général de l'Algérie a décidé de reprendre à loisir l'étude de la question et d'appliquer de rigoureuses mesures contre l'extension de la maladie.

Voici quelles sont ces mesures, présentées par nous et soumises à l'examen et à l'approbation du Gouvernement Général.

I. Service central de Léprologie.

Afin de connaître exactement le nombre des lépreux de l'Algérie, de pouvoir suivre chacun d'eux, d'unifier les mesures de prophylaxie,

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1) La Lèpre dans l'Afrique du Nord, l'invasion lépreuse en Algérie (Journal des maladies cutanées, Août 1903).

on centralisera au Gouvernement Général tous les renseignements sur la question. — Le Médecin, à qui seront communiqués tous les renseignements, préparera un questionnaire à adresser à tous les hôpitaux, aux Médecins de colonisation, etc., il sera consulté sur les cas doûteux, fera l'examen bactériologique des produits suspects, et indiquera en dernière analyse le régime auquel devront être soumis les malades en discussion.

II. Visite sanitaire dans les Ports.

Afin de diminuer le nombre de Lépreux d'importation, le service sanitaire maritime devra redoubler de surveillance sur les navires provenant d'Espagne, notamment d'Alicante et de Valence. Les Lépreux étrangers ne pourront pas débarquer et seront renvoyés chez eux, le navire sera désinfecté.

III. Traitement des lépreux étrangers.

A. Tout étranger qui désire s'installer en Algérie doit se faire immatriculer à la mairie de sa commune d'élection. L'Administration étudiera les moyens de faire visiter ces individus au moment de leur inscription, et de leur appliquer, s'ils sont lépreux et sans ressources, les arrêtés d'expulsion que la loi autorise contre les étrangers, lorsqu'ils deviennent un danger public. Jusqu'à présent ces arrêtés n'étaient éxécutés que pour des faits politiques, aucun texte n'empèche de les étendre au danger sanitaire.

B. Les étrangers déjà établis en Algérie, seront traités dans les mêmes conditions que les français et sujets français.

IV. Mesures immédiatement applicables, aux Lépreux existant dans la Colonie.

A. Une circulaire rappellera aux médecins et aux établissements hospitaliers que la déclaration de la Lèpre est obligatoire.

B. La plus grande discrétion étant nécessaire pour éviter aux lépreux d'être expulsés des locaux qu'ils habitent et d'être privés de leur gagne pain, la désinfection des vêtements, des meubles et des logements des malades sera practiquée sous la surveillance d'un Médecin spécialement désigné à cet effet.

C. Certaines professions comme celles de laitier, marchand ambulant de gâteaux, jouets, etc., soumise à l'autorisation municipale, seront interdites aux lépreux.

D. Dans les hôpitaux une salle spéciale où des Cabinets seront réservés à ces malades, de façon à obtenir un isolement relatif, suffisant s'il est accompagné d'autres mesures d'asepsie.

E. Autant que possible l'hospitalisation sera recommandée aux malades porteurs de lésions ouvertes (plaies, rhinite, etc.), après leur sortie ils trouveront dans les consultations gratuites des médicaments et des soins.

F. Si les ressources des Communes sont insuffisantes pour assurer l'hospitalisation ou la délivrance des remèdes à certains lépreux, le

Gouvernement Général prendra à sa charge les frais de traitements des lépreux indigents.

G. Visite des lépreux et de leur domicile à époques assez rapprochées; chacun d'eux possédera sa fiche sanitaire; il sera ainsi tenu une statistique exacte des cas existants. Le logement sera désinfecté régulièrement et la famille devra être avec ménagement mise au courant des dangers que présente le malade. Le Médecin chargé de ce service pourra délivrer à la famille une note indiquant les moyens de propreté et de prophylaxie, permettant d'éviter la contagion.

H. Enfin si en pays indigène des cas assez fréquents étaient signalés, on verrait à réunir les malades en un même point, de façon à créer une sorte de colonie, plus facile à surveiller et à soigner.

Holland und Kolonien.

Bericht

von

S. Mendes da Costa in Amsterdam.

Es ist mir die ehrenvolle Aufgabe gestellt worden, über den Stand der Verbreitung und der Bekämpfung der Lepra seit dem Jahre 1897 für Holland und Holländisch Indien zu referieren. Ich habe versucht, ein möglichst genaues, aber auch möglichst kurz gefasstes Bild dieser Materie zu geben, damit es eine bessere statistische Uebersicht gebe.

Bekanntlich hat Holland Kolonieen in Ost- und West-Indien. Ich teile meine Angaben in drei diesbezügliche Kapitel ein:

I. Holland.

Zur Zeit gibt es nur einen Fall autochthoner Lepra in Holland.

Der 57jährige Mann war nirgends wo anders als in Holland (nur einen Tag in Oldenburg in Westfalen) gewesen. Im Jahre 1897 zeigten sich bei ihm die ersten Erscheinungen dieser Krankheit, nämlich gelbbraune, runde Flecken und Ringe am ganzen Körper, später Anästhesieen der Extremitäten, Verlust der Augenbrauen, der Haare und Malum perforans pedum. Trotzdem es nicht gelungen ist, Leprabazillen zu finden, so ist an der Diagnose „Lepra anaesthetica“ nicht zu zweifeln.

Er hat die Lepra von seinem Bruder, der aus Ost-Indien angeblich mit Beri-Beri in seine Heimat zurückkehrte und im Jahre 1889 an „Lepra tuberosa“ erkrankte, acquiriert.

Beide Brüder wohnten lange Zeit zusammen.

Ausser diesem Fall sind mir noch 7 Leprafälle in Amsterdam bekannt (bei allen sind Leprabazillen gefunden worden). Sie betreffen alle Männer, die in Ost-Indien infiziert worden sind. Der Form nach sind diese Fälle: 5 gemischte, tuberöse und 1 anästhetische Lepra, mit dem autochthonen Falle 2 anästhetische.

Broes van Dort hat im Jahre 1897 17 Fälle von Lepra (in Holland) konstatiert; er glaubt aber, dass es deren noch mehrere gebe (30). Ich habe mir keine Meinung über die Zahl der Fälle in Holland bilden können, glaube aber mit mehreren Kollegen, dass die Ziffer zwischen 20

und 30 schwankt. Es gibt keine Lepra-Asyle in Holland; einige Krankenhäuser nehmen Lepröse auf, andere verweigern die Aufnahme. Seit dem Jahre 1897 sind in Holland keine Massnahmen von Belang getroffen worden, doch wurde die Errichtung eines Lepra-Asyles in Aussicht gestellt.

Im städtischen Krankenhause (Binnen Gasthuis) zu Amsterdam werden Lepröse mit Syphilitischen zusammen in demselben Raume untergebracht; sie haben eigenes Geschirr und eigene Wäsche.

II. Niederländisch West-Indien.

Broes van Dort fasste in der Dermatologischen Zeitschrift vom Jahre 1897 (S. 591) und in Mitteilungen und Verhandlungen der Leprakonferenz No. I, Abteilung IV (S. 3) alles Wissenswerte und Bekannte über die Lepra in West-Indien zusammen. Die Zahl Lepröser, inklusive der auf Curaçao, Aruba und Bonnaire, betrug im Jahre 1896 19 Fälle auf 38000 Einwohner. Auf St. Martin, Saba und Eustatius kamen in demselben Jahre 17 Fälle vor auf 5900 Einwohner. Diese Zahlen sind ziemlich genau, weil die Leprösen sich auf diesen kleinen Inseln schwer verstecken können. Sie werden in Lepra-Asylen untergebracht. Das Lepra-Asyl auf St. Martin ist aufgehoben, so dass es jetzt nur noch zwei, eines auf St. Eustatius und eines auf Curaçao gibt.

In Surinam ist die Zahl der Leprösen nicht bekannt; man weiss nur, dass sie viel grösser ist als auf Curaçao: auf 70000 Einwohner kommen 500—2000 Lepröse. Genaue Angaben sind nicht zu bekommen, weil den Kranken der freie Verkehr auf öffentlichen Strassen bei Strafe der Internierung in eine Isolierungsanstalt untersagt ist; die Folge davon ist, dass viele Lepröse sich verstecken.

Es gibt heutzutage zwei musterhafte neue Lepra-Asyle: erstens „Groot Chatillon“, gestiftet vom protestantischen Krankenverein, und katholische „Gerardus Majella-Stifting“; daneben wird noch die alte, weniger hygienische Anstalt „Batavia“ benutzt und vielleicht noch mehrere kleinere Lepraheime. Die Lepra wird in Surinam „Boasi“, das Lepra-Asyl „Boasigrond“ genannt.

Im März des Jahres 1903 hat der Gouverneur von Surinam eine Kommission beauftragt, der Leprafrage näher zu treten. Diese Kommission hat sich für Vergrösserung der Einrichtung „Groot Chatillons“ erklärt. Im September 1903 wurde von religiöser Seite beschlossen, das Krankenheim „Bethesda“ zu vergrössern, damit mehr Lepröse zur Aufnahme gelangen könnten (Dr. A. E. Post, Mededeelingen, Lepra 1904, Arnhem.)

Es ist mir nicht bekannt, für wie viele Kranken die Lepraasyle eingerichtet sind; in „Batavia“ waren im Jahre 1851 nicht weniger als 461 Lepröse anwesend, aber vermutlich sind heute keine oder nur einzelne noch da. „Groot Chatillon“ hat auf einer Grundfläche von 8 Hektar einige hölzerne Wohnungen für 10 – 14 Kranke, Badezimmer, Klosetts u. s. w. Wie vielen Kranken es jetzt ein Unterkommen gestattet, ist nicht bekannt.

Die obgenannte Absicht, eine Vergrösserung vorzunehmen, befasste sich mit der Frage, ob Wohnungen für 150 leichte und 60 schwere Kranke eingerichtet werden sollen.

In die Gerard Majella-Stiftung wurden im Jahre 1899 44 Lepröse aufgenommen.

III. Ostindien (Niederländisch).

Diese Kolonien mit 33 560 000 Einwohnern setzen sich zusammen aus einer Anzahl grösserer und kleinerer Inseln. Im Jahre 1865 wurde die Lepra von dem militärischen Chefarzt als nicht kontagiös erklärt. Infolge dessen wurden keine neuen Lepraasyle mehr gestiftet und viele alte geschlossen. Die Regierung unterstützte nur noch hier und da Privatanstalten. Erst in den letzten Jahren wird man wieder mehr und mehr von der Kontagiosität dieser Krankheit überzeugt, und infolge dessen fängt man wieder an, sich mit derselben zu beschäftigen.

Seit dem Jahre 1901 wird von Seiten der Regierung eine organisierte regelmässige Untersuchung der Anzahl der Leprafälle in Niederländisch-Ostindien angestellt. Ueberdies ist den einheimischen Regierungsbevollmächtigten anbefohlen, den Verkehr zwischen dem Volk und den Leprösen, soviel wie auf humane Weise möglich, einzuschränken und das Volk über die Gefahren der Lepra aufzuklären. Die Folge dieser Massnahmen ist, dass die Angaben über die Frequenz der Lepra in Ostindien seit dem Jahre 1902 ziemlich genau bekannt sind. Auch ist die Errichtung neuer Lepraasyle in Aussicht gestellt. Jetzt sind in Indien nur 5 Gouvernements-Lepraasyle, davon 3 auf Java; überdies ist in 18 Privatanstalten (5 auf Java) und in manchem chinesischen Spital Gelegenheit zur Aufnahme. Das am meisten hervorragende Lepraasyl befindet sich zu Pelantoengan. Auf Wunsch werden Leprakranke auf Kosten der Regierung frei dahingebracht, mit öffentlichen Fahrmitteln, unter Aufsicht eines Arztes.

A. Sumatra.

Diese Insel umfasst 6 Bezirke.

1. Atjeh. Die Bevölkerung in dieser Region isoliert ihre Leprösen aus eigenem Antrieb.

Broes van Dort (Histor. Stud. over Lepra, 1898. Hengel, Rotterdam blz. 47) berichtet von einem Kampong[1]), 800 m von Telok-Semawe entfernt, wo 12 Lepröse isoliert werden, und er gibt an, es seien auf Gedong noch einige Kampongs mehr, wo Lepröse wohnen. Die letzte Angabe umfasst 151 eingeborene Männer, 74 eingeborene Frauen und 3 Chinesen.

2. Westkust. Dieses Gouvernement ist eingeteilt in Padangs-Bovenlanden, Padangs-Benedenlanden und Tapanoeli. Hier befinden sich die meisten Leprösen im Bezirk Toba und Sinlindoeng. Auch hier isoliert die Bevölkerung, heute auf humanere Weise als früher. (Siehe Broes van Dort, loc. cit.)

Die folgenden Zahlen sind am Ende des Jahres 1902 angegeben:

Padangsche Bovenlanden: 236 Männer, 93 Frauen, alle Eingeborene; Padangsche Benedelanden: 324 Männer, 85 Frauen, alle Eingeborene; Tapanoeli: 241 Männer angegeben, von denen 227 noch nicht ärztlich

1) Dorf.

untersucht, und 61 Frauen, von denen noch keine untersucht ist, alle Inländer.

3. Oostkust. Auch hier kommt Lepra häufig vor. Eine zuverlässige Zählung ist nur unter den chinesischen Arbeitern an den Tabakplantagen möglich. Dagegen sind die Angaben über eingeborene Lepröse nicht kontrolliert. Im ganzen waren unter 129 inländischen Männern nur 14 kontrollierte Fälle; unter 43 kranken Frauen 4 ärztlich anerkannt. Hingegen waren nur 14 von 243 chinesischen Männern nicht ärztlich untersucht und von 4 chinesischen Frauen 3 noch nicht. Zwei fremde Orientalen wurden auch an Lepra erkrankt befunden.

Nach der Meinung der inländischen und chinesischen Behörden ist die Krankheit in Ausbreitung begriffen. In Medan, Binojei und Fano[illegible]o-jongpoera werden Lepröse in Krankenhäusern gepflegt, sie werden aber wenig beaufsichtigt. In Medan sind zwei Lepraasyle, von vermögenden Chinesen gestiftet.

Auch in Deli wurden früher Lepröse zwangsweise isoliert, (1890 bis 1896) 183 chinesische und 7 andere Leprakranke.

4. Benkoelen. Die Leprösen werden isoliert und von der Familie versorgt. Die Lepra scheint hier selten zu sein.

5. Lampong. Die Kranken wurden früher in den Wald geschickt und sich selber überlassen. In Benkoelen und Lampong zusammen werden 130 Männer und 38 Frauen als Aussätzige angegeben.

6. Palembang. In Palembang befindet sich eine Lepraanstalt, Kemang-Pampang, vom Gouvernement errichtet mit Raum für 50 Leprakranke.

Es werden in dieser Residenz ungefähr 653 Lepröse gezählt. Im Jahre 1902 wurden 410 Männer, 250 Frauen, alles Eingeborene, 2 chinesische Männer und 1 chinesisches Weib als Aussätzige gemeldet. Im ganzen sind also auf Sumatra mit einer Oberfläche von 420361 Quadratkilometern und mit einer Bevölkerung von 3000000 Einwohnern 2520 Lepröse angegeben. (1621 Indier, 644 indische Frauen, 248 Chinesen, 5 chinesische Frauen, 2 fremde Orientalen), das ist 1 Lepröser auf 160 Quadratkilometer und auf 1200 Einwohner.

B. Piouw.

Auf dieser Inselgruppe befinden sich 28 Lepröse: 7 inländische Männer, 1 europäische Frau, 18 Chinesen und 2 chinesische Frauen.

C. Banka und Billiton.

In Tandjong Poenai auf Banka befindet sich eine Anstalt zur Pflegung von 20 Leprösen. Die Krankheit ist hier aber nicht häufig. Auf einer Oberfläche von 16424 Quadratkilometern (Banka 11584, Billiton 4840) und bei einer Bevölkerung von 138158 Einwohnern (Banka 96763, Billiton 41395) wurden nur 24 Männer (7 inländische und Chinesen) und 3 Weiber (2 inländische und 1 Chinesin) als an der Krankheit leidend angegeben, d. h. 1 Lepröser auf 610 Quadratkilometer und auf 5120 Einwohner.

D. Java und Madoera.

Je mehr man vom Westen zum Osten geht, desto mehr mehren sich die Fälle. Um nicht in Wiederholung zu verfallen, verweise ich

den Leser auf die Arbeiten von Broes, Dort und von Post, wo man manche wissenswerte Angabe auf pathologischem und therapeutischem Gebiete finden wird. Hier beschränke ich mich auf statistische Angaben. Die meisten sind vom Chef des militärärztlichen Dienstes, Dr. Haga, im Jahre 1903 bekannt gemacht worden.

Die Inseln Java und Madoera haben 22 Residenzschaften.

1. Bantam (westlichster Teil). Auf 7326 Quadratkilometer und 652000 Einwohner keine Leprafälle konstatiert.

2. Batavia. Im ganzen 54 Fälle, davon 6 Europäer, 1 europäische Frau, 16 Chinesen, 2 chinesische Frauen, 21 Indier und 8 indische Frauen. 1 Leprafall auf 130 Quadratkilometer und auf 21500 Einwohner.

Im chinesischen Spital zu Batavia finden durchschnittlich 8 Lepröse ein Unterkommen.

3. Krawang. Keine Angaben, vermutlich keine oder nur vereinzelte Fälle.

4. Preanger. Im ganzen sind 8 Fälle konstatiert (5 Männer und 3 Frauen, alle Eingeborene). 1 Leprafall auf 2600 Quadratkilometer und 255000 Einwohner.

5. Cheribon. Hier sind 8 Aussätzige, 6 Eingeborene und 2 Chinesen angegeben worden, das ist: 1 Leprafall auf 850 Quadratkilometer und 185000 Einwohner.

6. Banjoemas. 58 Inländer, darunter 21 Frauen waren leprös, das ist: 1 Leprafall auf 100 Quadratkilometer und 21000 Einwohner.

7. Tegal (3782 Quadratkilometer und 1107725 Einwohner). Keine Angaben in Zahlen; es wird bloss berichtet, dass Lepra hier vereinzelt vorkommt. Im Lepraasyl zu Maratoea pflegt man hauptsächlich Luetische.

8. Pekalongan. Hier hat man 15 Fälle beobachtet, bei 11 Inländern und 4 inländischen Frauen, das ist: 1 Leprafall auf 120 Quadratkilometer und auf 37600 Einwohner.

9. Bengalen oder **Bangil.** Broes van Dort gibt an, dass hier 134 Aussätzige vorkommen (1890). Unter diesen waren 102 Männer (88 % tuberöse Lepra). 1 Leprafall auf 25 Quadratkilometer und auf 10000 Einwohner.

10. Kedoe. 30 Aussätzige, ebensoviele Männer als Frauen wurden hier angetroffen, das ist: 1 Leprafall auf 70 Quadratkilometer und auf 25000 Einwohner.

11. Samarang. Man zählte hier 50 Lepröse, nämlich 3 Europäer, 5 Chinesen, 3 chinesische Frauen, 33 Inländer und 6 inländische Frauen. Das Verhältnis ist: 1 Leprafall auf 100 Quadratkilometer und auf 29000 Einwohner. Hier wird im Militärspital eine Abteilung für Lepröse abgesondert. Auch werden Lepröse aufgenommen im Chinesischen Krankenhaus und im Armenhaus.

12. Japara (1790 Quadratkilometer und 564293 Einwohner). Von dieser Residenzschaft sind keine Angaben gemacht.

13. Soerakarta. Die hier aufgefundenen 34 Aussätzige betreffen: 1 Europäer, 1 Chinesen, 1 chinesische Frau, 19 Inländer und 12 inländische Frauen.

Unter dem Namen Sakietboeboek oder Sakietborak versteht man hier ausser Lepra noch manche sonstige Krankheit.

1 Fall auf 200 Quadratkilometer und auf 40000 Einwohner. Es gibt ein Lepraasyl in Wangkong.

14. Djokjokarta. Nur eine inländische Frau ist an der Krankheit leidend befunden. Im Jahre 1891 waren noch 7 Lepröse gemeldet. Das Verhältnis ist also: 1 Lepröser auf 3000 Quadratkilometer und auf 803000 Einwohner.

15. Rembang. 517 hier angetroffene Leprafälle betreffen: 368 Inländer, 129 inländische Frauen, 16 Chinesen, 3 chinesische Frauen, 1 Orientalen, das ist: 1 Leprafall auf 15 Quadratkilometer und auf 2500 Einwohner. Isolierung in einer Bambushütte in der Nähe der Hauptstadt.

16. Madioen. Die 54 Fälle waren wie folgt verteilt: 3 Europäer, 2 europäische Frauen, 21 männliche und 28 weibliche Eingeborene, also: 1 Leprafall auf 100 Quadratkilometer und auf 10000 Einwohner.

17. Soerabaja. In diesem Gebiete wurden 1055 Fälle, darunter 779 Leprafälle bei Männern konstatiert, das gibt: 1 Leprafall auf 6 Quadratkilometer und auf 2000 Einwohner.

18. Kediri. 551 konstatierte Leprafälle waren verteilt auf 372 eingeborene Männer, 175 eingeborene Frauen und 5 Chinesen, folglich: 1 Fall auf 14 Quadratkilometer und auf 2000 Einwohner.

19. Pasaroean. 424 Fälle von Aussätzigen, die hier angegeben sind, waren verteilt auf 300 Inländer, 121 inländische Frauen, 2 Chinesen und 1 fremden Orientalen, das ist: 1 Fall auf 12 Quadratkilometer und auf 2000 Einwohner.

20. Probolingo. Broes van Dort gibt an, es seien nur 7 Fälle in dieser Provinz vorgekommen, jüngere Angaben habe ich nicht erhalten können, also nur 1 Fall auf 500 Quadratkilometer und auf 80000 Einwohner.

21. Bezoeki (einschliesslich Banjoewangi). 37 Indier und 17 indische Frauen sind als Aussätzige angegeben, folglich: 1 Leprafall auf 250 Quadratkilometer und 20000 Einwohner.

22. Madoera. Diese nur 5286 Quadratkilometer grosse Insel ist relativ am meisten von der Lepra heimgesucht. Hier befinden sich ein Drittel aller Leprafälle, nämlich 1530 Aussätzige. Sie verteilen sich auf 1055 Inländer, 472 inländische Frauen, 2 Europäer und 1 Chinesen, das ist: 1 Leprafall auf 3,5 Quadratkilometer und auf 1000 Einwohner.

E. Bali und Lombok.

Nur indische Lepröse, 259 Männer und 99 Frauen (1902—1903), sind hier angegeben worden: 1 Leprafall auf 30 Quadratkilometer und auf 5000 Einwohner. Die Bevölkerung isoliert ihre Leprösen an verschiedenen Orten.

Da Angaben aus Krawang, Tegal und Japara mir nicht vorliegen, so ist die absolute Zahl der Aussätzigen auf Java und den umliegenden Inseln nicht genau anzugeben. Man kann aber annehmen, dass in den genannten Gebieten nicht viel Lepra vorkommt, sonst wäre es wohl von Broes van Dort und von anderer Seite veröffentlicht worden.

Die Summe der in den verschiedenen Provinzen angegebenen Fälle kann folglich als Minimalzahl angenommen werden. Sie wird, wie ich meine, der Wahrheit sehr nahe kommen.

	Residenzschaften	Inl. M.	Inl. Fr.	Eur. M.	Eur. M.	Chin. M.	Chin. Fr.	Or. Fremd
II.	Batavia	21	8	6	1	16	2	—
IV.	Preanger	5	3	—	—	—	—	—
V.	Cheribon	6	—	—	—	2	—	—
VI.	Banjoemas	37	21	—	—	—	—	—
VIII.	Pekalongen	11	4	—	—	—	—	—
IX.	Bangil	102	32	—	—	—	—	—
X.	Kedol	15	15	—	—	—	—	—
XI.	Samarang	33	6	3	—	5	3	—
XIII.	Soerakarta	19	12	1	—	1	1	—
XIV.	Djohjokarta	—	1	—	—	—	—	—
XV.	Rembang	368	129	—	—	16	3	1
XVI.	Madioen	21	28	3	2	—	—	—
XVII.	Soerabaja	779	276	—	—	—	—	—
XVIII.	Kediri	372	173	—	—	4	—	—
XIX.	Passaroean	300	121	—	—	2	—	1
XX.	Probolingo (7) . . .	—	—	—	—	—	—	—
XXI.	Bezoeki	37	17	—	—	—	—	—
XXII.	Madoera	1055	472	2	—	1	—	—
	Total 4584 = 7 +	3181	1320	15	3	47	9	2

Auf Java und Madeira. 1 Fall der Krankheit auf 30 qkm und auf 5500 Einwohner.

F. Borneo.

Nur die westlichen und südöstlichen Teile dieser Insel sind niederländische Besitzung (West 154 500 Quadratkilometer; Süd-Ost 374 400 Quadratkilometer). Die Angaben betreffen Personen, die Ende 1902 der Lepra verdächtig waren, aber die noch nicht ärztlich untersucht wurden. Insgesamt wurden gezählt 1187 lepröse Inländer, 785 inländische Frauen, 120 Chinesen und Fremde und 40 chinesische Frauen. 1 Leprafall auf 260 Quadratkilometer und auf 560 Einwohner.

Ein Lepraasyl, im Jahre 1897 gestiftet auf Singkawang, gibt nur 16 Leprösen ein Unterkommen.

G. Celebes.

Von 620 inländischen Leprösen waren 434 Männer, das ist: 1 Aussatzfall auf 200 Quadratkilometer und auf 620 Einwohner.

Die Bevölkerung fürchtet sich nur wenig vor Ansteckung.

H. Menado.

339 noch nicht ärztlich kontrollierte inländische Leprafälle, davon 118 Frauen.

1 Lepröser auf 170 Quadratkilometer und auf 1600 Einwohner.

I. Ternate.

Von 58 Leprafällen bei Männern war bei 22 die Diagnose von einem Arzte festgestellt worden. 12 von 41 als leprösverdächtige

Frauen waren gleichfalls sicher als Lepröse erkannt. Ueberdies sind 1 Chinese und 1 europäische Frau aussätzig befunden worden.

Im Jahre 1893 ist das Lepraasyl bei Ternate aufgehoben worden. 1 Lepröser auf 4570 Quadratkilometer und auf 1000 Einwohner.

K. Amboina.

Hier wurden 340 nur inländische Lepröse angegeben, davon 92 Frauen. Die Fälle sind noch nicht ärztlich kontrolliert.

L. Timor.

Im Ganzen wurden 8 Aussätzige, 5 Männer und 3 Frauen gemeldet; das ist: 1 Lepröser auf 5700 Quadratkilometer und auf 5000 Einwohner.

Nach Abfassung dieser Arbeit ist mir vom Militär - Chefarzt Dr. Haga eine verbesserte Angabe zugeschickt worden; daraus entnehme ich, dass Bangil keine selbständige Residenzschaft mehr ist, sondern zur Residenz Passoeroean gehört. Folglich sind die 134 Leprakranken aus Bangil schon in der Zahl der 424 Aussätzigen in Passoeroean einbegriffen, und wird die Gesamtzahl um 134 niedriger.

In Ost-Indien wurden also als an Aussatz leidend angegeben (nicht alle ärztlich kontrolliert):

		Indische und chinesische		Europäische	
		Männer	Frauen	Männer	Frauen
A	Sumatra	1871	649	0	0
B	Rioun	25	2	0	1
C	Banka und Billiton	24	3	0	0
D	Java und Madoera .	3128 (7)	1297	15	3
E	Bali und Lombok .	249	99	0	0
F	Borneo	1307	825	0	0
G	Celebes (Gouvern) .	434	186	0	0
H	Menado	221	118	0	0
I	Ternate	59	41	0	1
K	Amboina	248	92	0	0
L	Timor	5	3	0	0
		7571 (7)	3315	15	5

Total 10 913 Aussätzige.

1 Aussätziger auf 175 qkm und auf 3000 Einwohner.

Auf viele Fragen musste ich leider die Antwort schuldig bleiben; so war mir nicht möglich, Nachricht zu bekommen über die Anzahl Lepröser, die in Asylen untergebracht sind, über die durchschnittliche Dauer des Verbleibens in der Anstalt; auch war mir nicht möglich, mich zu erkundigen, wie die Leprösen zum Lepraasyl gelangen und wie sie sich dort beschäftigen. Auch über das Alter der Kranken und über die Form der Erkrankung fehlten meistenteils Angaben.

Mag auch bis jetzt manches in Dunkel gehüllt sein, so erwarte ich doch, dass man bald bessere Nachrichten bekommen wird, da Zeichen vorhanden sind, dass die Regierung sich mehr aktiv als vorher zu der Frage der Verbreitung und Bekämpfung der Krankheit stellen wird.

Island.

Bericht

von

Eduard Ehlers in Kopenhagen.

En 1897 j'ai présenté à la conférence de Berlin un rapport très succinct sur la lèpre en Islande (Compte-rendu de la conférence II, 22). J'y disais qu'une grande léproserie de 60 à 70 lits serait établie à Reykiavik, capitale de ce pays, et qu'une loi d'isolement, correspondant à la loi norvégienne, serait édictée sous peu. Cette loi d'isolement fut promulguée le 4 février 1898 et entra en vigueur trois mois plus tard. Bien q'à peu près analogue à la loi norvégienne du 6 juin 1885, elle en diffère en un point que je considère comme capital; aussi ai-je insisté sur ce paragraphe lors de la loi islandaise et je le ferai également adopter dans la loi qui va paraître sur la lèpre aux Antilles danoises.

J'entends ici le § 7, deuxième phrase: „Les enfants de parents lépreux dépendants de l'assistance publique seront toujours placés dans d'autres maisons.“ (Voir le texte entier de la loi — en anglais — dans Lepra, I, p. 152.)

La léproserie islandaise s'ouvrit le 10 octobre 1897. Vers la fin de ce mois elle avait déjà reçu 58 malades. Elle a coûté environ 130 000 couronnes, somme réunie par la charité privée sous les auspices d'un comité dont j'étais le secrétaire général et qui fut formé au sein de la branche danoise de l'ordre indépendant des Odd-Fellows.

La léproserie est située dans la presqu'île de Longarnoes à un quart d'heure de la ville de Reykiavik et s'appelle Odd-fellow-ordenens Spedalskhedshospital.

Du 10 octobre au 31 décembre 1897 le nombre des lépreux entrés dans cet hôpital a été de 81, mais ce chiffre a oscillé entre 60 et 70 durant les années suivantes, sans dépasser.

L'isolement des lépreux en Islande a pleinement confirmé les bons résultats obtenus en Norvège; ici le progrès se dessine encore mieux qu'aux léproseries norvégiennes, ce qu'explique peut-être le nombre relativement faible des lépreux libres, comparé à celui des patients que

cet hôpital peut isoler, savoir 60. D'après mes calculs, en 1894—95 l'Islande devait compter environ 200 lépreux, chiffre bas, comme l'ont clairement démontré les recherches qu'ont poursuivies après mon départ mes collègues islandais (voir le résultat du recensement de 1898). D'après le § 1 de la loi d'isolement les médecins sont tenus de déclarer tout cas de lèpre; les listes sont dressées tous les ans; le corps médical se distingue par son zèle en ces recherches et je regarde comme aussi exacts que possible les renseignements fournis par la statistique.

Or, d'après cette statistique la lèpre en Islande a subi une decroissance manifeste, le nombre des lépreux ayant diminué de plus d'un quart depuis l'entrée en vigueur de la loi d'isolement.

Fin janvier 1903 la léproserie avait isolé successivement 111 malades en tout. De ce nombre, 18 ne figurent pas sur la liste de 1896, bien que déjà malades à cette époque. Cette même liste ne mentionne pas non plus 12 individus que nous connaissons en dehors de l'enceinte du dit hôpital et pourtant la maladie s'était déjà alors manifestée chez eux. On peut donc prendre pour le total de 1896, 181 + 30 soit 211 lépreux, chiffre qui reste peut-être encore au dessous du vrai.

Donc aussi, en 1901 on avait constaté 133 cas, savoir:

61 malades entretenus, isolés, dans la léproserie (35 lèpre tub. 26 l. an.)
72 „ vivant dans le pays . . . . (38 „ „ 34 „ „)

soit en tout: lèpre tubéreuse . . . . 73 malades,
lèpre anesthésique . . . 60 malades.

Dans tous les pays scandinaves la forme tubéreuse est la plus fréquente; c'est à dire que la lèpre est plus maligne dans le Nord que dans les régions chaudes. La lèpre affecte une tendance bien plus marquée à devenir anesthésique, s'arrêter, voire même quérir dans les pays tropicaux et sous-tropicaux; maintes fois en mes travaux j'ai insisté sur ce fait. Les tropiques ne présent qu'un point où les formes tubéreuses prédominent comme chez nous, c'est la Nouvelle Calédonie.

Classés d'après le sexe les lépreux islandais sont répartis comme ci-dessous:

	Lèpre tubéreuse	Lèpre anesthésique
82 hommes . . .	43	39
51 femmes . . .	30	21

La liste suivante donne la répartition géographique des lépreux par départements (syssel).

Ejafiord reste, comme je l'ai signalé en 1894—95, le district le plus fortement éprouvé; mais Rangarvalla qui tenait le second rang en 1894—95, l'a cédé au département d'Arnès et ne compte plus que 7 malades.

Le département de Strande demeure immune.

Département	1894—95	1896	1901
Reykiavik	6	7	17
Kjos-Gullbringu . . .	13	16	14
Arnes	16	22	18
Rangarvalla	23	22	7
Skaptafell	4	5	3
Bongarfiord	12	14	} 5
Myra	3	3	
Snefellsnas	14	17	7
Dala.	2	4	4
Bardastrand	9	10	7
Isafiord	7	6	5
Strande.	—	—	—
Hunavatu	4	6	5
Skagafiord	7	6	8
Ejafiord.	27	28	22
Thingey	11	12	8
Nordur Mula	—	1	1
Sudur Mula	—	2	2
Total	158	181	133

Grönland.

Il n'ya pas et il n'y a jamais eu de lèpre en Groenlande. Les auteurs qui prétendent le contraire sont en erreur.

Ce fait négatif n'est point sans intérêt, pour les partisans de la théorie ichthyophagique de la lèpre, car les Esquimaux mangent beaucoup de poisson; inutile d'ajouter que leur poisson est souvent mal séché, même pourri; malgré cela: pas de lèpre.

Dänische Antillen.

La lèpre existait-elle déjà en Amérique à l'arrivée des Espagnols ou bien ceux-ci l'y ont-ils introduite? Et, dans ce cas, fut-ce surtout après que les nègres y devinrent esclaves? Depuis longtemps cette discussion est restée pendante.

Dans mes études préliminaires sur la question de la lèpre aux Antilles danoises[1]) j'ai dit que, suivant l'opinion unanime des auteurs, la lèpre n'a pénétré en Amérique qu'après la découverte de Chr. Colomb.

Toutefois j'ai recueilli ultérieurement des renseignements d'après lesquels cette maladie était déjà connue en Amérique avant l'arrivé des Espagnols. Nous ne parlerons pas ici des cruches de terre figurant comme antiquités péruviennes dans divers musées et qui représentent des caricatures d'individus mutilés et dans lesquelles certains savants ont vu des preuves d'une lèpre précolombienne. Les membres de la première conférence internationale tenue à Berlin 1897 au sujet de la lèpre, ont eu l'occasion de voir les cruches servant de documents à Virchow, et durent donner raison à Ashmead[2]) d'après qui les mutilations représentées n'ont rien à faire avec la lèpre; on doit plutôt, à l'exemple de Carasquilla, y voir des mutilations infligées comme châtiment de certains crimes.

Il me semble qu'il y a plus de force probante dans ce que relate[3]) le Dr. Jesus Chico (Mexique):

„Lorsqu'en 1519 les Espagnols firent leur première entrée au Mexique, ils constatèrent que la lèpre sévissait à Anahuac, c.-à-d. dans la vallée de Mexique et sur les plateaux attenants. Touché à la vue de tant de lépreux, Hernan Cortes fonda un hôpital pour eux, un lazaret, sur les rives du lac Texcoco, non loin de la ville de Mexique. A cette époque personne ne pouvait parler de la première apparition de cette terrible maladie dans le pays; mais tous les indigènes bien renseignés n'avaient qu'un dire, savoir que la lèpre était très ancienne et avait existé depuis aussi longtemps que les souvenirs pouvaient remonter.“

Nous avons des documents historiques sur au moins un lépreux de haut rang, Don Jimenez de Quesada, qui fit la conquête de la Colombie et mourut de la lèpre et de la syphilis vers l'an 1570; mais il est probable qu'il avait pris ces maladies en Espagne.[4])

L'hôpital St. Lazare de la Havane fut fondé en 1681 par le jésuite Don Pedro Alegre.[5])

Mais le facteur sociologique auquel la lèpre dut sa plus forte expansion en Amérique fut sans doute la traite des esclaves.

Une cinquantaine d'années avant que Colomb decouvrît l'Amérique, les Portugais avaient déjà commencé à trafiquer d'esclaves; mais ce commerce n'avait pas encore pris grand essor avant le début du XVIe siècle.

L'an 1500 le gouverneur Ovando obtint la permission d'introduire à St. Domingue des esclaves noirs qui avaient eu des maîtres chrétiens et les premiers nègres qui y débarquèrent, étaient nés à Séville, de parents africains achetés à des Portugais faisant la traite.

On sait que, plus tard le fameux Las Casas, évêque de Chiapa,

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1) Ugeskrft for Laeger 1898, Copenhague.
2) Mitteilungen u. Verhandlungen der I. Leprakonf. I, 4, p. 71. Berlin 1897.
3) Report of the Committee of national Leper Homes, Lepra III, fasc. 4, 1903.
4) Polakowsky, Vrhdl. d. Berl. anthropol. Ges. 16. Oktober 1897.
5) Manuel J. Alfonso, Leprosy in Cuba. Habana 1902.

fut cause que les esclaves noirs commencèrent à être de plus en plus employés au lieu des Indiens incapables de supporter le travail des mines de St. Domingue. En 1517 Charles Ouint autorisa l'introduction des esclaves noirs provenant des établissements portugais sur la Côte d'or.

C'est vraisemblablement ainsi que la lèpre dite „Cucubay" fut importée aux Antilles.[1])

Ce furent surtout les Anglais qui déployèrent de l'activité dans le commerce des esclaves. Sire John Hawkins de Plymouth inaugura en 1580 ce nouveau trafic par trois traversées du littoral africain au Brésil. La reine Elisabeth le fit chevalier en reconnaissance de ce qu'il faisait pour la prospérité nationale et, durant les trois siècles qui suivirent, les Anglais exploitèrent si bien cette source de richesse qu'ils coupèrent l'herbe sous les pieds de leurs plus proches concurrents, les Portugais et les Français.

De 1680 à 1700 il y eut en tout 300 000 nègres transportés d'Afrique à la Jamaïque seulement, et de 1700 à 1796 ce chiffre monta à 600 000. Il y avait des lépreux dans ce nombre: nul n'en saurait douter, s'il a lu les recherches de Tonkin sur la repartition actuelle de la lèpre dans le Soudan.[2]) A la Jamaïque Hans Sloane observa un cas de lèpre en 1687.[3])

Toutefois les maladies infectieuses chroniques, lèpre comprise, ne jouaient pas de rôle important parmi les nègres, tout que dura l'esclavage. Sans doute la lèpre se recrutait d'une importation continue d'Afrique; mais c'est à supposer que des individus fortement attaqués et exposant à des dangers sérieux n'ont pas été importés, car ils gâtaient les autres marchandises et étaient eux-mêmes des articles de commerce sans valeur. Quant aux malades chez qui la lèpre était latente et qui par suite réussirent à débarquer, ils ne compromettaient que peu la santé publique ou bien on les évinçait du personnel du plantage quand leur maladie perçait et pouvait être constatée.

Il est triste de constater le fait, que l'abolition de l'esclavage des nègres constitue une manoeuvre trop hâtée, une faute d'économie sociale qui a compromis par une brèche irréparable l'hygiène des villages occupés par les nègres des plantages. Dans le bon vieux temps un médecin attitré inspectait tous les nègres du plantage; les malades étaient placés dans une infirmerie sous la surveillance d'une infirmière (sick-nurse). Les enfants dont les mères travaillaient aux champs étaient soignés par une vieille négresse et tous les dimanches les négrillons étaient présentés au maître du plantage, qui distribuait des primes en argent aux mères qui arrivaient au concours avec les enfants les plus luxuriants de santé.

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1) Cucubay ou Cocobay, à Cayenne Cocobé, est pour les nègres le nom populaire de la lèpre. Je ne saurais expliquer l'origine de ce nom. Dans son rapport (Report relating to the origin and prevalence of leprosy in the United States from the surgeon-general of the Marine Hospital service Washington 1902, p. 94) le Dr. Murray dit que ce nom vient d'une localité de l'archipel Bahama, où la maladie était commune ainsi qu'à Rock Sound.

2) Lepra III, p. 314.

3) Ashmead, Introduction of leprosy into America by negroes. Virginia medical Semimonthly, 12 June 1896, p. 150.

Mais lors de l'abolition de l'esclavage, le nègre devint cet homme libre qui de nos jours encore ne fait qu'à regret des efforts pour travailler et rarement amasse plus d'argent qu'un dollar, la dépense en un tour de main et jamais ne met de l'argent de côté pour les dépenses imprévues. Le nègre malade dut alors se soigner lui-même. Une maladie chronique l'attaque-t-elle, il se tire d'embarras soit en continuant à vivre en parasite dans le village, si le propriétaire du plantage est assez coulant pour le laisser séjourner; ou bien il se dédommage d'être chassé, en végétant à l'aide de la mendicité et du vagabondage. Cependant, ce qu'il nous manque, c'est non seulement des dénombrements mais encore des moyens de jauger le mal qui n'a pas manqué de croître depuis l'affranchissement des nègres.

Jusqu'à l'insurrection de 1878 à Ste. Croix, l'ensemble des choses alla passablement, car les règlements relatifs au travail statuaient, que les planteurs devaient assurer à leurs nègres cinq jours de travail par semaine à 10 cents par jour (soit environ 50 centimes; notez qu'aujourd'hui la main-d'oeuvre a pour le moins doublé). De plus le maître devait à ses nègres la gratuité des soins médicaux et des remèdes ainsi que d'un lot de terre ou jardin potager.

Les frais pour consultation et médecine gratuites étaient alors dans les plantages de

1ère	classe	3	cents	par	semaine	par	nègre
2me	„	2	„	„	„	„	„
3me	„	1	„	„	„	„	„

que les maîtres retenaient sur le salaire des nègres.

Mais après l'insurrection de 1878 les maîtres cessèrent de s'intéresser à cet état de choses et les contrats furent résiliés pour presque la moitié des plantages, surtout à l'extrémité occidentale de Ste. Croix, parce que la loi ne réglait pas cet état d'une manière rassurante, dont on aurait spécialement besoin de nos jours.

Ce qu'on a dénommé „Le règlement de la domesticité" du 24 Octobre 1876, contient dans le 3e alinéa de son § 16 une clause vague imposant aux planteurs le soin des malades „sauf décision différente".

Un dispositif du 2 Octobre 1862 (§ 8d) améliore pourtant la condition des immigrants: on ne doit leur refuser la gratuité, ni du logis, ni des consultations, ni des remèdes et ils sont sur ce pied durant deux ans.

Après l'insurrection de 1878 la plupart des planteurs prirent donc „d'autres décisions"; mais depuis 1888 nombre de planteurs sont néanmoins revenus à l'inspection médicale fixe.

En fait de caisse pour maladies, il n'en est qu'une, et toute petite et sans importance, fondée par la paroisse luthérienne de Christiansted.

Jusqu'en 1884 on n'a rien fait pour les lépreux. Le 29 Novembre 1884 parut une ordonnance pour la confection d'un règlement sanitaire pour Ste. Croix. (A l'heure présente St. Thomas n'a encore rien obtenu de pareil.) Le 21 Décembre 1885 le conseil colonial decréta pour les villes de Christiansted et Frederiksted un règlement sanitaire assez utile confirmé par le gouverneur Arendrup le 30 Janvier 1886, mais on n'en fait jamais application parfaite.

Dans ce règlement sanitaire le 2 alinéa du § 33 prescrit que „les lépreux seront isolés de la manière fixée par le conseil de santé".

Les lépreux qui dépendent de l'assistance publique, peuvent, si le conseil de santé le juge nécessaire, être internés au frais du public dans un hôpital spécialement affecté à ce service. Les règles pour le soin des patients seront établies par le gouvernement (voir: Organisatoriske og reglementariske Bestemmelser for de offentlige Hospitaler paa Ste. Croix af 1 Nov. 1888). C'est à cette mesure sanitaire qu'on doit la fondation du lazaret de Richmond à Ste. Croix, ouvert le 1er Mars 1888 et qui commença par 13 lépreux auxquels furent adjoints cinq autres un peu plus tard dans le cours du mois, puis 11 encore durant l'année, ce qui fait un total de 29.

Le mouvement du personnel malade de l'établissement de 1888 à 1903 se manifeste dans le tableau ci-joint (p. 86).

Morts entre 10—20 ans . . . 9
„ „ 20—30 „ . . . 27
„ „ 30—40 „ . . . 11
„ „ 40—50 „ . . . 11
„ „ 50—60 „ . . . 13
„ „ 60—70 „ . . . 1
„ „ 70—80 „ . . . 1

Aperçu des entrées et sorties en lazaret depuis sa fondation jusqu'à l'heure présente.

Année	Nombre au 1er Janvier	Entrées durant l'année	Sorties dans le cours de l'année			Nombre au 31 Décembre
			Desertés	Morts	autres causes	
1888	0	29 1)	1	4	—	24
1889	24	11	4	4	1 2)	26
1890	26	3	1	10	0	18
1891	18	4	0	5	0	17
1892	17	5	0	4	1 3)	17
1893	17	1	0	4	0	14
1894	14	5	0	2	0	17
1895	17	6	1	1	0	21
1896	21	2	2	2	0	19
1897	19	15	0	9	0	25
1898	25	6	1	7	0	23
1899	23	6	3	6	0	20
1900	20	9	0	5	0	24
1901	24	8	0	5	0	24
1902	27	10	1	4	0	32
1903	32	7	1	1	3 4)	34
	Ensemble	127	15	73	5	—

1) 13 le 1er Mars, 16 plus tard. — 2) Envoyé à St. Thomas. — 3) Libéré sur sa demande. — 4) Transférés à l'hôpital comme incertains.

La moyenne des malades présents a été 22 soit env. $^1/_5$ du nombre des lépreux vivant en liberté non isolés sur nos îles.

Il est presque impossible de dire si la lèpre a augmenté ou décru dans les îles. Je regarde comme vraisemblable que cette maladie ait diminué. Bien que l'asile de Richmond soit loin de l'idéal, on doit pourtant reconnaître, qu'il a rendu service, car un cinquième des malades les plus contagieux a été forcé de vivre surtout dans l'enclos de l'établissement.

Le ci-devant inspecteur de Richmond, Mr. Dendtler déclare qu'il y a une vingtaine, une trentaine d'années, la lèpre se propagea aux plantages de Granard, Canegarden, Retreat, Diamond, Humbug et Jérusalem, une sagefemme lépreuse ayant répandu la contagion au loin. Je n'ai rien pu recueillir de plus détaille là-dessus.

En 1893 je soulevai en Danemark la question de la lèpre islandaise et le mouvement s'est communiqué aux Antilles danoises; en 1894, à l'instigation du royal collége de santé, l'on reçut de bons et amples rapports sur l'expansion aux îles de la lèpre et en 1895 il y eut avec le Ministère des finances des pourparlers dans le but de me stipendier pour un voyage d'exploration audit pays; mais ce voyage n'eut pas lieu, bien que sans faute de ma part.

Les rapports très substantiels et très complets qui ont paru en 1894, m'ont fourni les extraits que voici[1]).

Le Dr. Mortensen, médecin inspecteur de St. Thomas et St. Jan, s'exprime ainsi: „D'après un dénombrement récemment fait par le rapporteur et dans lequel il a examiné personnellement tous les malades, sauf deux, qu'il ne lui a pas encore été possible d'aborder, il y a pour le moment à St. Thomas 20 patients souffrant de la lèpre, y compris un malade, habitant Hans Lollik, île du voisinage. (Une lettre du 18/6. 1896 y ajoute 2 cas constatés et 2 autres suspects [illegible]s.) Les deux sexes s'y font bien pendant, dix de chaque; quant à l'âge, on trouve 3 enfants au-dessous de 13 ans (11 pour le plus jeune [illegible]e), 4 ayant moins de 18 ans, le autres étant entre 20 et 67. Au point de vue de la position sociale 5 malades doivent être rapportés aux classes supérieures, tous les autres sont de bas étage et de la couche infime de la population. Autant qu'on sache, 5 sont des blancs dont un „Chacha" (ce sont des pêcheurs français venus de St. Martin) 5 sont des nègres et le reste se compose d'individus diversement colorés. Au nombre des patients il n'y a aucun blanc immigré et durant ces six dernières années aucun blanc n'a été atteint du mal. C'est ici l'opinion favorite que les juifs sont spécialement exposés à prendre la lèpre et l'on doit avouer que l'état de choses constaté ne justifie pas peu cette manière de voir; car 7 de nos lépreux sont juifs ou d'origine israélite, et 4 d'entre eux très proches parents; 2 sont frère et soeur, les 2 autres leurs enfants. La maladie se manifeste sous ses deux formes; la forme tubéreuse est plus fréquente que la forme anesthésique. Tous les quartiers de la ville ont fourni leur contingent, et, vu la fréquence des déménagements, tel demeurait dans l'Est de la ville, qui deux mois après en habitera l'extrême Quest, en sorte qu'il ist difficile

1) Sundhedskollegiets Aarsberetn., p. 314. Copenhague 1896.

d'assigner un foyer spécial à la lèpre. Un seul patient est établi à la campagne. La population fait tout pour cacher ces malades, sans doute en partie par crainte de les voir arrachés de chez eux et expédiés à Ste. Croix. On doit donc s'attendre à ce que quelques cas aient échappé à l'attention; toutefois, le nombre que l'enquête a atteint est assez fort pour nous tenir en éveil à notre poste. Le dernier recensement estime à 12 000 habitants la population de St. Thomas; mais depuis lors l'émigration et la mortalité l'ont tellement réduite que le total doit à peine arriver à 10 000 personnes dont 20, soit 2 pour mille, sont lépreuses[1]); il est même probable que la situation est encore plus fâcheuse, car, ainsi qu'on l'a indiqué, il faut tenir compte des quelques cas qui peuvent s'être soustraits aux recherches."

La réalité de cet échappement fut constatée en 1897; on savait que St. Thomas comptait alors 21 lépreux et 2 malades suspectés de lèpre; 6 lépreux étaient morts, mais il en était venu quatre nouveaux qui tous étaient malades depuis nombre d'années et par conséquent avaient échappé au recensement de 1894 (Dr. E.).

Le Dr. Mortensen, inspecteur médical, continue ainsi: „Si l'on prend surtout en considération l'expansion assez forte à laquelle la lèpre semble être parvenue actuellement, les mesures opposées jusqu'ici à ce fleau doivent passer pour tout à fait insuffisantes, car elles consistent essentiellement à transporter à Ste. Croix au sortir de l'hôpital communal les lépreux qui dépendent de l'assistance publique. A cet egard il est grandement déplorable que dans cet hôpital l'agencement ne permette pas d'isoler les malades qui y séjournent; même en supposant, ce qui n'est pas toujours réalisable, qu'on puisse les tenir chacun dans une chambre ou cellule, ils n'en trouveront pas moins divers moyens d'avoir contact avec les autres personnes qui vivent à l'hôpital. Cet état de choses couve un danger qu'on ne peut parer qu'en agençant pour les lépreux une petite section isolée, soit contiguë à l'hôpital soit encore plus à l'écart. De temps à autre on interne un malade dont la maladie est encore douteuse; souvent alors il y reste assez longtemps soumis à l'observation, jusqu'à ce que sa maladie ait évolué à point pour assurer le diagnostic et même dans le cas où le caractère de la maladie ne laisse aucun doute, il se passe toujours un certain temps avant qu'on puisse réaliser le transport à Ste. Croix.

Les autres lépreux, et ils sont nombreux, échappent pour ainsi dire à tout contrôle; plusieurs d'entre eux circulent sans empêchement dans les rues; ils sont dans les boutiques, où tout naturellement ils palpent, pèsent et manient soit des denrées alimentaires soit des articles de vêtement qui vont être vendus à d'autres. Je laisse de côté les dangers d'un pareil contact au point de vue de la contamination; mais c'est toujours là un abus dégoûtant qu'on devrait absolir carrément. Il appert que tel malade travaillait récemment chez un boucher et probablement aussi prenait par à la vente de la viande. Même dans les familles assez à l'aise, où le malade est caché à la

1) Dans ce rapport l'inspecteur médical M. Mortensen omet les lépreux appartenent à St. Thomas, mais transportés à Richmond en Ste. Croix.

maison, en général à ause de son horrible aspect, il n'est point question d'isolement effectif; en entrant, un étranger peut bien voir le malade s'empresser de disparaître de la salle où se tient la famille, mais maintefois il ne pourra pas éviter de s'asseoir sur un siège ou un sopha que le lépreux vient de chauffer.

Une commune aussi petite et nettement délimitée que la nôtre doit présenter des conditions particulièrement favorables pour contrôler et combattre une maladie comme la lèpre d'ont l'orgine et l'allure dépendent, il est vrai, de diverses circonstances qui ne sont pas toutes bien connues, tandis que son expansion est, en tout cas pour la majeure partie, attribuable à la contagion. Les médicins et les fonctionnaires de la police connaissent à fond la populatation; en travaillant de concert ils réussiraient petit à petit à découvrir tous les cas réels et, sans grande difficulté l'on pourrait réaliser une ou deux fois par an une perquisition systématique de la ville et de la campagne. Les représentants du corps médical et de la sûreté publique devraient, d'après ordres et instructions, avoir l'oeil constamment fixé sur la lèpre et dénoncer à l'inspecteur tout cas nouveau; ce dernier se rendrait alors compte, par lui-même autant que possible, de l'état de tous les malades et de leurs conditions d'existence, on tiendrait balance exacte et ferait un rapport annuel au gouvernement et au collége de santé, en même temps qu'assisté au besoin par la police, il ferait exécuter les mesures prises par ordre supérieur du gouvernement.

Ces mesures là devraient sans doute viser surtout à isoler malades autant que possible, les contrôler constamment ainsi que leur entourage et pratiquer la désinfection requise par les circonstances. Dans la plupart des cas c'est tout au plus si les rapports sociaux et la gestion des fonds permettront d'isoler; mais, l'observance de prescriptions formelles et la commission à un certain contrôle devraient être obligatoires même pour les familles aisées, à qui de considérations spéciales feraient permettre de garder dans leur sein les malades.

Néanmoins la question d'isoler et contrôler le lépreux présente en son ensemble des difficultés telles qu'il pourrait y avoir lieu de suggérer que l'affaire fût discutée par le collége de santé ou par une autre commission nommée ad hoc."

L'affaire a été traitée à fond par le collége royal de santé qui proposa les mesures désirées.

Mais aussi l'on s'en tint là.

Dans ses rapports ultérieurs l'inspecteur médical M. Mortensen a réclamé coup sur coup une meilleure organisation; mais ce n'est encore qu'un pieux désir.

L'inspecteur médical de Ste. Croix, le Dr. Kalmer, rapporte ce qui suit: „Concernant d'abord l'apparition de la lèpre dans notre île, voici dans les tableaux ci-dessous les résultats donnés par les recherches faites avec l'aide de deux médecins publics à Christiansted et à Frederiksted.

Les sexes étaient représentés respectivement par 36 hommes et 46 femmes.

T = forme tubéreuse; A = forme anesthésique; M = forme mixte.

Résidence	Hommes			Femmes			Total
	Forme T	Forme A	Forme M	Forme T	Forme A	Forme M	
Asile pour lépreux	3	8	2	2	5	2	22
Ville de Christiansted . . .	7	3	0	1	3	2	10
Plantages aux environs . . .	1	4	0	2	4	0	11
Asile de Richmond	—	—	—	—	—	1	1
Sans domicile fixe	—	1	—	—	—	—	1
Ville de Frederiksted	1	2	1	4	4	1	13
Plantages aux environs . . .	1	5	1	3	11	1	24
Total	13	23	4	12	27	7	82[1])

1) Une lettre du 20 Mars 1896 révéla ultérieurement 4 nouveaux cas de lèpre.

Tous ces malades, à un près qui était marchand, appartenaient à la classe inférieure et à la population ouvrière.

Leurs âges étaient de 0—10 ans pour 2 d'entre eux
" " " " 11—20 " " 18 " "
" " " " 21—30 " " 21 " "
" " " " 31—40 " " 16 " "
" " " " 41—50 " " 20 " "
" " " " 51—60 " " 4 " "
" " " " 61—70 " " 1 " "

En 1897 on découvrit L St. Croix 9 nouveaux cas, savoir:

Hommes			Femmes			Total
T	A	M	T	A	M	
—	3	1	1	4	—	9

mais il y eut en même temps 11 décès. 1897 devait donc compter 84 lépreux vivants. Il est aisé de voir que le nombre est assez stationnaire:

Nombre des lépreux dans toutes les 3 îles

	en 1894	1897	1902
St. Thomas	20	21	13[1])
Ste. Croix	82	84	86[2])
St. Jan	—	—	1

Mes recherches de 1903 justifient l'exactitude du nombre de l'épreux rapporté pour St. Thomas et St. Jan par l'inspecteur médical M. Mortensen.

1) Plus 6 malades transférés de St. Thomas à Richmond (Ste. Croix).
2) A déduire 6 malades de St. Thomas à Richmond (Ste. Croix).

Par contre les chiffres que donne l'inspecteur médical M. Kalmer dans son rapport du 26 Janvier 1903, savoir 86 lépreux à Ste. Croix, sont erronés (voir la liste), car 2 patients, no. 18 et no. 24, se sont trouvés identiques aux nos. 69 et 98, et 8 des lépreux portés sur la liste comme vivants étaient déjà morts, comme l'a fait constater l'enquête, savoir

le no. 41 † le 28/9. 1898		le no. 63 † le 16/8. 1897
„ „ 43 † „ 21/1. 1901		„ „ 71 † „ 12/7. 1893
„ „ 45 † „ 23/9. 1898		„ „ 74 † „ 21/10. 1899
„ „ 56 † „ 16/7. 1901		„ „ 76 † „ 29/1. 1902

Un neuvième malade, le no. 77 émigra aux Barbades le 13 Mai 1898 avec un passe-port du gouvernement.

Un patient, le no. 48, avait échappé à mes recherches. Il était porté sur la liste de l'inspecteur dans la colonne des domiciles inconnus et, après mon départ, on constata que depuis le 20 Juin 1899 il était interné dans l'hospice des aliénés de Richmond.

En faisant des recherches à Ste. Croix jais réussi à découvrir encore 19 malades qui manquaient sur la liste officielle de cette île.

Enfin l'on ne saurait hésiter à rayer de cette même liste 3 patients, chez qui je n'ai pu trouver trace du lèpre, savoir, nos. 35 († 20. 9. 1903), 42 et 47.

Pendant mes investigations les nos. 4 et 89 moururent, mais leurs places sont déjà occupées par d'autres, échappés à mes perquisitions et dont l'un, no. 119, fut découvert par l'inspecteur médical M. Mortensen, l'autre no. 120 se signala lui-même à la police.

Total des lépreux actuellement en vue 106.

Résidant à	Hommes		Femmes		Ensemble
	T	A	T	A	
Ste. Croix . .	11	36	6	33	86
St. Thomas .	2	2	6	9	19
St. Jan . .	0	0	0	1	1
Total	13	38	12	43	106

La liste ci-dessous porte 86+13 lépreux portés pour l'année 1903 aux listes officielles des inspectorats médicaux de Ste. Croix et St. Thomas, plus les 19 nouveaux amenés par les recherches que j'ai faites à Ste. Croix.

Sous le rapport des deux formes qu'affecte la maladie il n'y a donc que 25 malades attaqués de la lèpre tubéreuse maligne, les 81 autres n'ayant que la lèpre bénigne du type anesthésique. Sous les climats boréens, en Scandinavie, le rapport des formes tubéreuse et anesthésique est celui de 1 à 2. En Crète j'ai constaté une sorte de parité: 51 à 46. On peut donc dire qu'aux Indes occidentales la maladie se montre très bénigne.

Liste des lépreux des Antilles danoises en 1903.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
1	Homme	60 (envir.)	Christiansted	des Barbadesen 1863	Lèpre an. mut.	Interné Richmond 1888, oncle maternel du no. 107.
2	H.	37	Glynn. Né à Marys Fancy		L. an.	Int. Richmond 1888. Début à 15 ans. Tante pat. morte de L. an. à Marys Fancy.
3	Femme	60	Née à Hams Bay		L. mut.	Interné Richmond 1888. Tous doigts tombés.
4	F.	32	St. Thomas		L. an.	Int. Richm. 1889, nièce du no. 38. Morte 20/2. 1903.
5	H.	44	Work and Rest. Né à Annas Hope.		L. mut.	Interné Richm. 1890; mal. depuis 1878.
6	F.	23	St. Thomas.		L. tub.	Accouch. 9/6. 1903, garçon sain. Vagabonde, raccroche autor de l'asile; souvent rattrapée.
7	F.	69	La Grange. Née à Hermon Hill		L. an.	Interné Richmond 1894.
8	H.	28	Carlton.		L. an.	Interné Richmond 1897.
9	F.	20	Mt. Pleasant. Née à Peters Rest		L. an.	Int. Richm. 1897. Mal. depuis âge 6 ans. Sa mère avait la lèpre anesthésique.
10	H.	40	Mt. Pleasant. Né à Lebanon Hill		L. mut.	Int. Richm. 1897. Tous doigts tombés.
11	H.	16	Frederiksted		L. tub.	Interné Richmond 1897.
12	F.	37	St. Georges. Née à Marys Fancy.		L. mut.	Int. Richm. 1897. Mal. depuis âge 14 ans. En 1901 congé de 3 jours, passés en visite à St. Georges où dev. enceinte. Accouch. 27/12. 1901 dans l'asile; enfant encore sain, mais vivant parmi les lépreux de l'asile.
13	H.	27	Castle Coakley. Né à Anguilla.		L. an.	Interné Richmond 1898.
14	H.	33	Prosperity (Westend)	des Barbades, 1890	L. an.	„ „ 1899.
15	F. (hindoue)	42	Christiansted	de St. Kitts, en bas âge	L. an.	„ „ 1900.
16	H.	23	St. Thomas. Né à Krause		L. tub.	„ „ 1900.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
17	H.	14	Frederiksted		L. an.	Interné Richmond 1901, cousin de no. 18.
18	Femme (identique de 69)	25	Frederiksted		L. mut.	Int. Richm. 1901, cousine de no. 17. Mal. dep. 10 ans.
19	Homme	28	Annaly		L. tub.	Int. Richmond 1900; [illegible] gardait bestiaux avec un [illegible] homme (no. 63) qui mourut [illegible] de L. an.
20	H.	30	Strawberry Hill.		L. mut.	Int. Richm. 1901; mal. [illegible] dep. 7 ans; père mort de [illegible] L. an.
21	H.	25	St. Georges		L. tub.	Interné Richmond 1901. [illegible]
22	F.	46	Frederiksted		L. mut.	„ „ 1901. [illegible] malade depuis âge 14.
23	F.	34	River		L. an.	Perdu tous doigts du [illegible] du pied gauche, quelques [illegible] uns du pied droit. Cong[illegible]gé 1/1. 1903; désertée; re[illegible] reprise à River, réfugié[illegible]iée chez son fils. Morte au[illegible] automne 1903 à l'hôpital Frederiksted.
24	H. (identique 58)	18	Christiansted		L. mac.	Interné Richmond.
25	H.	12	Né Constitution Hill		L. an.	„ „ 190[illegible]2.
26	H.	20	Peters Rest		L. an.	„ „ 190[illegible]2.
27	H. (hindou)	51	St. Thomas	de la Guadeloupe il y a 10 ans; de Calcutta il y a 20 ans	L. mut.	„ „ 190[illegible]2, mort 1/9. 1903.
28	H.	41	Hope.		L. mut.	Interné Richmond 190[illegible]2: mère morte de L. an.
29	H.	28	Jealousy. Né Upper Love.		L. an.	Interné Richmond 190[illegible]2. Simple atrophie du thén[illegible]ar et de l'inteross. I. Nom[illegible]r. plaies aux jambes.
30	H.	46	Concordia (près Christiansted)		L. tub.	Interné Richmond 19[illegible]2. Père mort de L. tub. [illegible] à Two Friends.
31	F.	50	St. Thomas		L. tub.	Interné Richmond 19[illegible]2 en Août; accouch. da[illegible]s l'asile le 29/10. 19[illegible]2, garçon sain dont le pè[illegible]re est à la Jamaïque.
32	F.	50	St. Thomas Née à St. Jan		L. an.	Interné Richmond 19[illegible] en Août. Servi 7 ans ch[illegible]e une lépreuse (no. 90), p[illegible] la lèpre la 6 me ann[illegible]é
33	H.	29	Shoys. Né à Canaan		L. mut.	Interné Richmond 19[illegible] Lépreux à 16 ans. T[illegible] doigts tombés. Ta[illegible] morte à Canaan de tub.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
34	H.	22	Marys Fancy	des Barbades 1903	L. an.	Interné Richmond 1903. Pied droit écrasé voiture il y a 2 ans. Orteil occupé par un grand et douloureux ulcère. Les 2 doigts voisins tombés.
35	H.	35	Grande Princesse		Crespature tend.	Int. Richm. 1903, Janv. N'est pas lépreux. Mort de Morbus mentalis 20/4. 1903.
36	H.	52	Concordia		L. an.	Evadé de l'asile. Introuvable.
37	Homme	40	Lebanon Hill		L. an.	Un des premiers internés à Richmond en 1888. Evadé 4 à 5 fois. Dernier internem. 27/2. 1897. Congé 1/5. 1899: déserté 4 ans à St. Georges. Introuvable durant mon séjour. Repris à Little la Grange. Réinterné 7/3. 1903.
38	H., charpentier	60	Christiansted		L. an.	Vit de charpentage; malade depuis 26 ans. Oncle du no. 4.
39	H., marchand	35	Christiansted		L. mut.	
40	H.	28	Christiansted		L. mut.	Atteint à 18 ans. Pied gauche: reste gros orteil et 2d doigt; d'ailleurs ce pied a l'aspect d'un moignon après une amputation à la Syme. Aboutissement complet à l'âge de 20 ans. Air bien portant.
41	H. (indigent)	66	Christiansted		L. tub.	A tort sur la liste offic. Mort 28/9. 1898.
42	H., pêcheur	33	WorkandRest		L. tub.	Pas de lèpre.
43	H.	16	Inconnu			A tort sur la liste offic. Mort 21/1. 1901. Malade depuis son 13me an.
44	Femme, incapable de travailler	27	St. Georges		L. mut.	Neveu lépreux (no. 60).
45	F. (indigente)	69	Christiansted		L. an.	A tort sur la liste offic. Morte 23/9. 1898.
46	F. (indigente)	51	Christiansted		L. mut.	Il y a 12 ans perdu pouce gauche et les 3 doigts uln. contractés. Du reste remuante et bien portante; mendie par la ville.
47	F. (indigente)	53	Christiansted. Néa à Frederiksted			Non lépreuse. Nul signe de lèpre. Syph. mut. Ulcera cruris pedumque.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
48	F. (indigente)	50	Inconnu		L. tub.	Introuvable durant mon séjour. Plus tard découverte à la section des aliénés de Richm; là depuis 20/8. 99.
49	F.	90	Fredensborg		L. an.	Morte dit-on depuis 4 ou 5 ans à St. Georges, mais vivant à Fredensborg selon l'inspecteur Kalmer Soeur du no. 60.
50	F., gardeuse de moutons II. classe	35	Mon Bijou		L. mut.	Mariée; homme sain; 6 enfants, tous morts; cousine du no. 103.
51	F.	55—60	Christiansted. Née à Glynn.		L. mut.	Petite fille perdit 2d orteil gauche, 2d et 3me droits, pas d'autre souvenir. Mal. stationnaire.
52	F., cuisinière chez un officier de la garnison	60	Christiansted		L. mac. an.	
53	Femme, incapable de travailler	26	Bettys Hope. Née à Coopers Negrobay		L. mac.	Mal. depuis 4 ans. A Bettys Hope vécut jusqu'à il y a 2 ans le lépreux no. 85.
54	Homme, viv. du travail qu'il rencontre	19	Frederiksted		L. an.	Se dit neveu paternel d'un lépreux.
55	H. (pècheur)	17	Frederiksted		L. tub.	Mal. depus 3 ans. Son frère mort l'an dernier de L. tub. Ils vivaient ensemble.
56	F.	25	Frederiksted		L. an.	A tort sur la liste offic. More 16/7. 1901.
57	F.	30	Frederiksted. Née à Oxford ou à Orange grove		L. mut.	
58	H. (ident. 24)	14	Christiansted		L. mut.	
59	H.	25	Wheel of Fortune. Né à Becks Grove		L. tub.	Père, ouvrier à Mannings Bay, mort à Richmond de L.tub., il y a 12 ans.
60	H.	20	Montpellier (Westend)		L. tub. mut.	Mal. passée à la phase an., toutes tubérosités s'effacent. Mal. depuis 4 ans; frère du no. 49, neveu du no. 44.
61	H. (gardien)	50	St. Georges.		L. mut.	Mal. dès lenfance; mère lépreuse. Tous doigts perdus il y a 25 ans. Maladie station. depuis lors. Quand on l'explore il danse, badine et fait claquer ses moignons en ricanant. Doubles paralysies faciales; mari du no. 75.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
62	H., ouvr. 2d cl.	30—32	Bettys Hope.		L. mut.	Mal. depuis 4 à 5 ans.
63	H.	33	Williams.		L. an.	Travaillé avec no. 19. A tort sur liste off., mort 16/8. 1897.
64	H.	24	Mt. Washington; doit se tenir à Frederiksted		L. an.	Introuv. durant mon séjour.
65	F.	57	Frederiksted		L. mut.	Mal. dès l'enf. Double paral. fac.; mains attaquées aux artic. metacarp.
66	F.	66	Frederiksted		L. mut.	Mal. depuis 40 ans.
67	F.	35	Frederiksted		L. mut.	„ „ 18 „
68	F.	51	Frederiksted		L. mut.	„ „ 1867. Mal. stationnaire: pas empiré depuis 20 ans.
69	F. (ident. 18)	22				
70	F.	22	Frederiksted		L. an.	N'a plus que les métacarp.; se dit contaminée par une cousine.
71	F.	54	Concordia		L. tub.	A tort sur liste off.; morte 12/7. 1893.
72	F.	28	Frederiksted		L. mut.	Grandmère pat. lépreuse. Frère mort de L. an.
73	F.	35	Wheel of Fortune (aupar. Becks Grove)		L. mut.	Mal. depuis 18 ans. A de plus une éléph. de la jambe droite. Oncle pat. mort de L. an.
74	Femme	25	Carlton		L. an.	A tort sur liste off. Morte 21/10. 1899.
75	F.	28	Campories		L. an.	Mariée à no. 61.
76	F.	21	Prosperity		L. tub.	A tort sur liste off. Morte 21/10. 1902 à la section des aliénés de Richmond. Affectée égalem. d'éléphantiasis.
77	F.	45	Prosperity		L. an.	A tort sur liste off. Emigra aux Barbades 3/5. 1898.
78	F. mariée	41	Little la Grange		L. an.	
79	F.	45	Lower Love		L. an.	Grand-mère lépreuse. Introuvable durant mon séjour: doit être à Annas Hope.
80	F., incapable de travaill.	19	Adventure		L. mut.	
81	F.	25	Mannings Bay. Née à Bettys Hope		L. mut.	Paral. faciale.
82	Homme	35	Frederiksted. Né à Mount Pleasant		L. an.	Mal. depuis 5 ans.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
83	H., charpetier	29	Frederiksted. Né à Two Friends		L. mut.	Mal depuis 2 ans.
84	F., incapable de travaill.	50	EnfieldsGreen	d'Antigua 1867	L. mut.	Vit chez un compatriote dans le plantage.
85	F., incapable de travaill.	38	St. Georges. Née à Cotton Grove		L. tub.	Mal. rétrogr. Mal. depuis l'âge de 19 à 20 anns. Tombée malade à Bettys Hope. A une fille de 2 ans, lépreuse (Liste no. 102).
86	H.	21	Bethlehem		L. an.	Introuvable, mais supposé à Bethlehem.
87	F.	65	Johns Fooly en St. Jan. Née à St. Thomas		L. mut.	Se rappelle d'une lépreuse du plantage Carolina, morte depuis longtemps.
88	F.	52	St. Thomas		L. an.	Mal. dés ses 18 ans. Frère mort 31/3. 1902 de la lèpre. Fille de sa soeur morte 6/9. 1897 de L. mixta. Un fils d'une autre soeur, cousin de cette morte mort 28/8. 1899 de la dysenterie pendant la lèpre anesth. Une fille du frère nommé en 1er lieu, morte le 17/3. 1897 de la lèpre.
89	F.	55	St. Thomas		L. mut.	Morte durant mon séjour, 14/3. 1903.
90	F.	60 (envir.)	St. Thomas		L. an.	Paral. fac. A contaminé no. 32 qui servait chez elle.
91	F.	48	St. Thomas		L. an.	—, a, pendant 4 ans, partagé le lit d'une femme qui mourut de la L. mixta 27/9. 1900.
92	F., ci-devant laveuse	45	St. Thomas	de Trinidad, à St. Croix en 1867 Née à Tortola	L. tub.	Se dit infectée par le linge sale. Malade depuis 5 ans.
93	Homme, chez ses parents	14	St. Thomas. Née à Ste Croix		L. tub.	Mal. depuis 7 ans; frère du no. 94. Mère saine; son 1er mari était de famille lépreuse.
94	F., chez ses parents	17	St. Thomas		L. tub.	Mal. depuis 7 ans. Soeur du no. 93.
95	F., ci-devant couturière	45	St. Thomas		L. mut.	

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
96	F., repasseuse vend du charbon et des provisions	52	St. Thomas	née à Tortola	L. tub.	Type retrograde.
97	F., dessinet et peint	19	St. Thomas		L. tub.	
98	F., ci-devant cuisinière	71	St. Thomas. Née à Ste. Croix		L. an.	A appris qu'une fois elle a dormi dans le lit d'un patient affecté de lèpre.
99	F., laveuse avitailleuse	58	St. Thomas	de S. Kitts 1849	L. an.	
100	F., laveuse	45	St. Thomas. Née à St. Jan		L. an.	
101	F.	28	Ste. Croix. Christiansted		L. tub.	
102	F.	2	St. Georges (Ste. Croix)		L. mac.	Fille du no. 85. N'a de taches que sur la joue gauche.
103	F.	35	Christiansted		L. an.	Mal. depuis ans 5 ans. A eu 11 enfants dont 6 morts. Porte dans son giron un enfant d'un an, rachitique et de piteuse mine. Cousine du no. 50.
104	H., ouvrier II. classe	18	Bethlehem old Works	de S. Kitts 1898	L, mac. anesth.	Camptodactylia dx. atrophies musculaires de la main. Mal. depuis 3 ans.
105	H.	35	Bethlehem new Works. Née à Two Friends		L. mac.	Taches sur tout le corps. Anesthésie de la région ulnaire. Plaies perforantes aux plis des phalanges et dans le gros orteil droit.
106	H., berger II. classe	28	ManningsBay. Née Annaly.		L. mut.	Grand-père pat. de sa mère lépreux.
107	F.	24	Christiansted		L. tub.	Mal. depuis 3 ans. Sa mère est soeur du no. 1.
108	F.	38—40	Work and Rest. Née à Barren Spot		L. mut.	Perdu tous doigts du pied droit et phalangette de l'orteil gauche, il y a vingt ans.
109	Femme	14	Shoys		L. tub.	Mal. depuis 1 an. Oncle mat. de Southgate Farm mort lépreux il y a 14 ans, mais inconnu à la malade, mais elle a connue le no. 33.
110	F.	34—35	Sion Farm		L. an.	Phalangettes du IIIe et IVe doigt de la droite tombées. Petite camptodactylia du Ve doigt (Main en griffe) et anesthésie ulnaire de la main gauche. Tomba malade à Big Diamond il y a 14 ou 15 ans, Mal. stationnaire depuis 13 à 14 ans.

No. d'ordre	Désignation	Age	Domicile (Résidence)	Immigré	Forme de maladie	Remarques particulières
111	Homme vit chez s. grand-mère et sa tante	19	Frederiksted		L. tub.	Oncle mort il y a 20 ans de L. tub.
112	H.	14	Frederiksted		L. tub.	
113	H., ouvrier aux champs	54	Slob	de Nevis 1861	L. an.	
114	H., berger II. classe	18	Fair Plain, New Bethlehem. Né à Carlton		L. tub. (mixte)	Souffre aussi d'éléph. dx.
115	H., garde	35	Annaly		L. tub. l. gr.	
116	F.	15	Frederiksted		L.mac.	Léprides zébrées le long des bras sur les lignes de démarcation de Voigt.
117	H., cocher	40	Jealousy		L. an.	N'a plus que le petit doigt droit. Au reste parfaitement en état de travailler.
118	F., inspectrice (fait souvent les fonctions de sage-femme)	50	Williams	des Barbades vers 1861	L. tub.	Interné à l'asile de Richmond.
119	H.	16	St. Thomas		L. an.	Découvert par l'inspecteur médical Mortensen après mon départ.
120	H.	15	Christansted. Née à Mont Pleasant		L. an.	Intern. à Richmond 6/4. 1903. Sa mère l'a tenu enfermé durant tout mon séjour dans l'ile et ne voulait le laisser voir par personne; ce ne fut que le 6/4. qu'il s'échappa et courut à la police pour se faire interner à Richmond.
121	H.	32	North Star (Ste. Croix)		L. an.	Réclamé, mais jamais vu.

On peut voir la résidence des lépreux sur la carte ci-jointe (fasc. 2) où chacun des malades est représenté par un point rouge.

Par résidence on entend le domicile ou logis, mais quand il s'agit des patients internés à Richmond, la résidence est indiqué d'après le dernier domicile qu'ils avaient avant d'entrer dans la léproserie.

L'éloignement de la mère-patrie a écarté d'elle tout danger sérieux dont la menacèrent le foyer relativement vaste de lèpre dans les Antilles danoises. Néanmoins on n'a pas pu empêcher quelques étincelles échappées de ce grand foyer d'atteindre le Danemark, où fort heureusement, autant que l'on sache, elle n'ont pas mis le feu. Dans le cours des années trois cas de cette maladie sont parvenus à la connaissance des médecins danois.

Le premier de ces cas fut rapporté par Brünniche en 1861[1]. Il s'agissait d'une fille de 6 ans, la petite B., fille d'un commissaire de police des Antilles et qui fut probablement contaminée par sa bonne noire. 37 ans plus tard j'ai décrit[2] l'état de cette malade qui vit encore, à Copenhague, et souffre de la lèpre anesthésique mutilante.

Le second cast est fourni par un ci-devant soldat des Antilles, Jörgen Carl S., dont la maladie a été décrite par R. Bergh[3]. Egalement atteint de lèpre mutilante, il avait fait 8 ans de service aux Antilles, et vivait de charpentage: jusqu'à ce que son mal le rendit incapable de travailler. Il fit plusieurs séjours à l'hôpital du roi Frédéric, en 1841, 1844—45, 1847—48 et 1850—56, et pendant ce temps perdit tour à tour le pouce gauche, l'annulaire gauche, l'avant bras droit et l'oeil gauche, se servit des trois doigts qui lui restaient à la main gauche pour vendre des cigares sur l'endiguement de la vieille route royale, ce qui dura quelque deux ans, puis le 1er Août 1856 il mourut de tuberculose pulmonaire.

Le 3me cas est le plus triste de tous et tout à fait récent: la victime est un des médecins attitrés de Ste. Croix, qui dans l'exercice de ses fontions contracta l'infection en accouchant une négresse chez laquelle plus tard il constata la lèpre. Durant ses manoevres d'obstétrique il se blessa au doigt; la plaie mit longtemps à guérir; plus tard il éprouva dans ce doigt des névralgies lancinantes et il évolua ensuite chez lui une lèpre anesthésique malheureusement trop bien caractérisée.

Ledit médecin a dû abandonner toutes ses fonctions médicales et mène aujourd'hui à Copenhague une existence pitoyable à l'aide d'une maigre subvention que lui fait la caisse coloniale de Ste. Croix.

Les asiles de Richmond sur l'île de Ste. Croix.

Richmond était autrefois un plantage, situé à dix minutes de marche de Christiansted. L'emplacement est bon et défie toute objection, mais l'établissement est un pêle-mêle de prison, hospice d'aliénés, dépôt de mendicité et léproserie et ce motif suffirait à le déclarer impropre à l'usage.

La cour est spacieuse mais traversée, dans une tranchée bée, puante et non encore chaussée, par les eaux réunies du relavage et de vidange qui se perdent au hasard sous le mur de la prison. Dans cette cour les prisonniers sont en train de tiller le brou de coco, tandis que d'autres internés font les lézards au soleil et tuent le temps de leur mieux; parmi eux, des mendiants hébétés et séniles, des aliénés

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1) Hospitalstidende 1861, p. 61—62 et 65—67.
2) Cas de lèpre mutilante à Copenhague. Ugeskrift for Laeger 1898.
3) Hospitalstidende 1862, p. 35.

assez calmes et les patients qui ont des ulcères aux pieds („sore-foot“ des Anglais).

A l'arrière-plan de la cour de la prison se trouvent 9 grandes cages à bêtes fauves (je ne peux pas trouver d'expression mieux appropriée) dont les grillages en fer s'ouvrent sur la cour, en sorte que les mendiants et les lépreux peuvent passer leurs heures de loisir à se moquer des êtres que renferment ces coffres à fous, ou à s'en indigner ou bien à les taquiner; quelques-uns de ces prisonniers enragent et ébranlent les grilles, pendant qu'une pauvre femme constamment occupée à mettre en lambeaux ses vêtements, doit se résigner à ce qu'on l'encaisse complètement et ne lui laisse qu'un petit trou en haut pour l'air. Il n'y a que 9 cages pour les malades qui ont perdu la raison, mais comme l'hôpital compte toujours une vingtaine et plus de ces patients, il en résulte qu'au moins une vingtaine d'aliénés doivent être logés parmi les „pieds ulcérés“. Il va de soi qu'on met en cage les plus turbulents, mais les plus paisibles sont abandonnés auxdits „pieds ulcérés“.

A 8 heures du soir on ferme toutes les ouvertures et met les volets et ne rouvre qu'à 6 heures du matin. Tout naturellement la surveillance est nulle dans ces salles encombrées où dorment de 14 à 16 patients dans un espace qui suffirait à peine à la moitié moins.

Or, qu'un des fous ait subitement un accès durant le nuit; il arrivera de deux choses l'une; ou bien il fera un massacre parmi les „pieds ulcérés“ ou, ce qui est aussi vraisemblable, les „pieds ulcérés“ qui ne sont pas accoutumés à montrer de la patience dans le traitement des aliénés, emploient des arguments frappants pour lui apprendre qu'on ne doit pas déranger le repos nocturne d'autrui.

Le Dr. Heyn, médecin attitré, ne loge pas dans l'établissement. Il se plaint qu'on puisse avoir de pareilles scènes dont aucun surveillant n'est témoin. Les lits n'existent pas à l'hôpital: il y a eu quelques traillis en bois; le Dr. Heyn vient de faire monter des toiles sur des cadres, et les malades peuvent y reposer plus mollement que sur les traillis. Je saute la description de l'état où se trouvent ces toiles. Les planchers ont tous de grandes crevasses et des trous; le pis est naturellement dans les cages des fous où ces malades mettent leur ardeur à démolir ce que l'inspecteur des bâtiments met beaucoup de temps à faire reconstruire.

Le murs et chanbranles de la section des „pieds ulcérés“ sont mous et pourris; en tapant sur les parties en bois on fait pleuvoir punaises et cafards.

Quant aux latrines, je dois dire que jamais je n'ai vu d'installation aussi dégoûtante dans un hôpital. Jadis il y avait cinq sièges dans chaque cabinet; mais les traverses de trois d'entre eux sont brisées, en sorte qu'il ne reste plus maintenant qu'un ravin béant. Lors de ma visite il y avait dans une petite construction latérale flanquée de deux latrines, un mendiant couché qui cherchait à relever le moral d'un aliéné mélancholique, et un aveugle les écoutait. Les malades sont en haillons et l'on ne voit que saleté.

Les „Dispositions organisatrices et réglementaires des hôpitaux publics de Ste. Croix“ s'expriment ainsi touchant ces établissements:

Dans les hôpitaux de Richmond sont traités tous les hommes appartenant à la classe inférieure et atteints de folie ou de lèpre, ainsi que les malades porteurs d'ulcères ouverts et chroniques.

En outre ces hospices donnent des soins à tous les incurables des deux sexes du dépôt de mendicité.

La section des aliénés a un bâtiment spécial; neuf fous peuvent y avoir chacun sa cellule.

La section des hommes de la basse classe qui ont des ulcères chroniques aux pieds et aux jambes, et la section des incurables des deux sexes du dépôt de mendicité, occupent le reste des infirmeries dans la cour de la prison et, de plus, le petit hôpital pour Yaws situé hors de l'enceinte de cette cour. On y trouve un hôpital à 2 salles pouvant contenir 22 lits,

un étage au-dessus de la section des fous, à 8 salles et pour 16 lits,

un petit bâtiment dans la cour des malades, à une salle et pour 4 lits,

l'hôpital pour Yaws à une salle et pour 11 lits (soit en tout 53 lits).

La léproserie ressort au dépôt de mendicité; elle a 6 salles et peut recevoir 35 malades.

Ces établissements sont soumis, non seulement au règlement disciplinaire générale, mais encore aux règles particulières qui suivent:

Les patients de la léproserie ne doivent quitter l'asile que sous surveillance. On peut les visiter, mais en présence d'un surveillant et seulement à la porte de l'établissement.

A l'hôpital pour ulcères et à la léproserie, tous les patients capables de travailler sont tenus de faire tout le service de ces sections et d'exécuter, en outre, des travaux en rapport.

Voici l'ordre du jour: Au lever du soleil les patients sont réveillés, se lavent et s'habillent, mettent les salles en état, nettoient et aèrent la literie et balayent la cour. Le nettoyage terminé, le surveillant fait l'inspection des locaux et mentionne les infractions constatées qui sont aussitôt réparées.

Après le déjeuner les patients se mettent au travail, de 8 h m. à 1 h s. et quand ils ont diné ils le reprennent de 3 à 6.

A 7 heures l'hôpital (asile) est fermé.

Le travail se fait dans la cour des malades ou sur le terrain de la prison de Richmond ou dans ses champs; il consiste, non seulement en toutes les manoeuvres qu'exigent le nettoyage et l'entretien de l'établissement, mais encore à faucher, cultiver la terre etc., à faire des ouvrages de vannerie ou tels autres que détermine l'inspecteur.

Les malades ne doivent pas travailler avec les prisonniers et l'uniforme d'hôpital qu'on donne diffère, par la couleur, de celui de ces derniers.

L'inspecteur a reçu aux asiles de Richmond des instructions spéciales d'après lesquelles il tiendra la main à réduire au minimum compatible[1]) avec un traitement convenable des internés, les dépenses

1) Quand le Conseil colonial songe à économiser sur le budget, sa première

de l'hospice, ce dernier devant être, dans une certaine mesure, considéré comme réfuge. Cet inspecteur aura soin de tenir les lépreux suffisamment séquestrés pour prévenir tout contact avec le monde extérieur dont la santé publique pourrait avoir à souffrir. A cet égard il doit se règler sur prescriptions détaillées du médecin.

La carte des hôpitaux de Richmond est ainsi rédigée:

8 h m.: $^1/_2$ litre d'eau chaude (sic!) et 45 g de sucre candis et 125 g de pain beurré. — Diner 3 h s.:

Dimanche et Jeudi: $^1/_2$ litre potage gras (boeuf) aux légumes et 125 g bouilli;

Lundi: $^1/_2$ litre potage au concombre ou autres végétaux, au lard;

Mardi: $^1/_2$ litre potage farineux (fèves, haricots) au lard;

Mercredi et Samedi: $^1/_2$ litre potage petits pois au lard;

Vendredi: bol de gruau d'orge à la melasse.

A chacun de ces repas les internés ont 250 g de pain de seigle.

Le régime extra, purement exceptionnel, comprend le lait[2]), la bière, les spiritueux, ainsi que les salés et le sagou. L'entretien des lépreux figure au budget pour 1600 dollar, ce qui pour l'asile comprenant 35 patients, fait à peu près $12^1/_2$ cents par jour[3]) et par personne.

Etudions maintenant de plus près l'état des choses dans cet établissement, telles qu'elles y sont en réalité; car sur le papier, nous venons de le voir, tout a très bonne façon.

L'établissement est agencé pour loger 35 patients; c'est donc là son premier défaut, il n'y a pas assez de lits: car il ne peut admettre que le tiers du contingent lépreux des îles. Les deux autres tiers doivent vivre en dehors de l'asile et leur condition d'existence est telle que la contagion doit incessamment s'entrenir hors de l'enceinte hospitalière de Richmond. Mais il faut encore insister: l'asile est trop petit pour 35 malades. Le plan ci-joint montre l'aire disponible. Les salles sont trop petites pour être, comme elles le sont, encombrées de malades. Quant à la petite cour, ou petit jardin, si l'on veut, on y trouve pas d'ombrage, pas de serre où les patients puissent s'abriter contre le soleil; il sont forcés de rester dans leurs petites cages surchauffées. Conformément à la règle, ils sont enfermés à 6 heures au coucher du soleil et doivent ainsi, bon gré mal gré, rester, chacun avec son vase de nuit sous le lit, dans une petite salle jusqu'à ce qu'on leur ouvre le lendemain matin. De n'importe quelle salle on peut appeler le surveillant en tirant un cordon de sonnette.

Le nettoyage des salles et de l'enceinte des murs est fait, bien que grandement à contre-coeur, par les malades qui ont des mains. L'urinoir est inconnu, remplacé qu'il est par n'importe quel point de la petite cour, au choix de chacun.

Les malades n'ont pas chacun sa cuvette (de fer-blanc); ceux qui

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pensée plane sur les lépreux. Il vaudrait peut-être mieux leur réserver la dernière pensée quand il s'agit d'économie.

2) Actuellement il n'y a que 5 malades qui reçoivent chacun $^3/_4$ litres de lait. On ne distribue jamais d'oeufs. Tous les malades reçoivent tous les jours pour 2 cents de Salep.

3) A la léproserie de Sandy Point (St. Kitts) que j'ai visité, on calcule 15 cents par jour.

en manquent, la remplacent par leur vase de nuit. On voit dans le plan ci-dessus que dans un coin de l'établissement il y a une petite salle de bain; mais qu'en peuvent faire les malades quand il n'ont rien pour se savonner? je ne le comprends pas.

Jusqu'ici les malades de l'établissement entier ont eu à dépenser 15 cents par semaine pour se laver le corps, pour la lessive des vêtements et bandages etc. Pour cette modique somme on a une barre de savon, dont la longueur n'excède pas 30—45 cm et qu'il faut partager en 35 morceaux d'égale grosseur.

L'essuie-main est inconnu.

Il n'y a pas une seule chaise dans l'asile, mais seulement quelques bancs de bois très primitifs et sans dossiers.

On ne connait ni couteau ni fourchette. Les nègres n'ont peut-être pas encore perdu l'habitude de manger avec les doigts; mais quand ces malheureux lépreux ont perdu jusqu'aux doigts, ils ne peuvent pas s'en tirer sans couvert.

Rien, absolument rien n'est fait pour utiliser le temps des pauvres malades qui n'ont plus de doigts ou de mains; ce dont on manque le plus, c'est une petite collection de livres.

Pour leurs menues dépenses les malades reçoivent 5 cents par semaine et les emploient à acheter surtout du tabac qu'ils fument dans l'immanquable pipe en terre. Pour se garnir la poche ils troquent volontiers leurs aliments, surtout le lard. Comme on le voit par la carte réglémentaire, ils ont 4 fois par semaine du lard salé. 4 rations de ce lard s'achètent en ville, à Christiansted, pour 30 ou 40 cents: or, quand 4 lépreux ont mis en bloc leur portion de cette denrée, qu'ils ont touchée de leurs mains mutilées ou couvertes de plaies, ils trouvent des acheteurs criminels qui leur en donnent de 5 à 6 cents.

Pour les pansements on a, mais par pure exception, des tissus de coton neufs, qu'on doit alors découper en bandes prêtes à employer; car si on ne découpe pas la pièce, les lépreux la vendent et se contentent de la vieille toile à sac (canevas etc.), mise au rebut par l'intendance militaire et impregnée d'huile et autres matières.

Le dépôt de la léproserie est un débarras où l'on met toute espèce de pots cassés, cruches, vases et tasses, ainsi que des articles d'équipement provenant d'autres magasins, surtout des dépôts militaires. Ces objets sont encore bons pour les lépreux.

L'alimentation a le tort d'être en partie réglémentée d'après les idées reçues en Danemark. Le pain de seigle ne fait pas le caprice des nègres; les lépreux ont du mal à le mâcher et à l'avaler: il leur cause des maux de gosier. Voici déjà plusieurs années que l'inspecteur leur donne du pain blanc en échange.

Et, sur une plainte analogue à propos du régime du vendredi, ce gruau d'orge, qui avec le cours du temps s'était transformé en gruau de riz, cet inspecteur donna aux malades le mets favori des nègres. la soupe de farine jaune (farine de maïs, fungy) et la morue sèche, L'inspecteur actuel M. Christiansen, entré en fonctions le 1er Janvier 1903, poursuit la même réforme avec la même intelligence, bien que de son propre chef, et le médecin attrité, le Dr. Heyn l'approuve.

Il y aurait certainement de bonnes raisons pour forcer encore la proportion de maïs dans l'avitaillement des lépreux; car dans les conditions normales le nègre raffole de voir chaque jour ce plat.

Les écuelles de fer blanc où l'on distribue la nourriture et qui tiennent lieu d'assiettes, se rouillent très vite, mais on n'ose pas les mettres au rebut avant que la rouille les ait trouées. On devrait préférer des écuelles émaillées.

Le Dr. Heyn, médecin publique de Christiansted, fait sa visite tous les jeudis et dimanches.

L'asile loge donc un tiers des lépreux de l'archipel et, si seulement on isolait convenablement ces malades, par une séquestration réelle, dans la léproserie même on aurait déjà réalisé un progrès. Mais il manque une loi d'isolement et il en résultate qu'on ne croit pas devoir retenir les malades dans la léproserie contre leur gré.

Le Dr. Heyn pense que, pour prévenir les évasions, il sera forcé d'accorder aux malades les mieux en voie de guérison, de petites vacances qu'ils utiliseront pour visiter leurs amis et connaissances à la ville et à la campagne. Or, voici des observations qui font voir comment on utilise ces vacances.

Le **No. 6**, 23 ans, attaquée de lèpre tubéreuse, est une vilaine coureuse; elle rôde en dehors de l'asile quand l'envie lui en prend et il faut souvent la rattraper. Ses escapades sont cause que le 9 Juin 1903 elle accoucha dans la léproserie d'un garçon bien portant.

Le **No. 12**, 37 ans, souffre de lèpre mutilante. En 1901 on lui permit de s'absenter pendant 3 jours; elle en profita pour visiter le plantage de St. Georges et y devint enceinte. Le 27 Décembre 1901 elle enfanta dans l'asile. Son enfant vit aujourd'hui parmi les lépreux, à charge de l'établissement et ne manquera pas d'attraper un beau jour la maladie, si on l'y laisse séjourner.

Le **No. 15**, femme hindoue, est frappée de lèpre anesthésique. Le 6 Mars 1903 l'inspecteur la surprit derrière le mur de l'asile, couchée dans l'herbe et en train de se mesurer avec un homme de la ville, non lépreux.

Le **No. 23**, atteinte de lèpre anesthésique, obtint un congé le 1er Janvier 1903 et disparut.

La police „ne put pas la trouver". J'appris qu'elle avait d'un fils à River; j'y allai à cheval, fis appeler le fils et le sommai d'amener sa mère, faisant semblant de savoir que je la savais cachée là, et elle y était de fait.

Le **No. 31**, 50 ans, accoucha le 29 Octobre 1902 dans l'asie, d'un garçon bien portant dont le père est à la Jamaïque.

Le **No. 36**, 52 ans, lèpre anesthésique, a déserté l'asile et jamais depuis on ne l'a retrouvée.

Le **No. 37**, 40 ans, lèpre anesthésique, fut une des premières qu'on internât dans l'asile à 1888; elle s'en est échappée 4 à 5 fois et n'y a été réinternée que sur ma requisition le 1 Mars 1903.

La section des „pieds ulcérés" de Richmond ou plutôt la section infirmière des malades ayant des plaies aux pieds et jambes, provient naturellement de ce que les nègres sont incapables de se soigner en cas de maladie.

Au temps de l'esclavage, en effet, tout esclave capable de travailler, qui négligeait une pareille blessure ou plaie, était, sans autre forme de procès, mis à l'hôpital du Plantage; on lui prenait le pied sain dans une cangue et soignait le pied malade jusqu'à guérison complète, ce qui rarement prenait beaucoup de temps. Mais une fois l'esclavage aboli, ce fut une vraie fête pour les nègres d'attraper ces blessures insignifiantes au début et qu'ils négligeaient exprès, car la douleur les exemptait du travail. Il est évident que le nègre, allant nu-pieds, est fort exposé à de pareilles lésions qui, négligées, peuvent prendre un caractère très sérieux et, peut-être plus souvent qu'on ne croit, constituent la porte d'entrée ou la lésion initiale de la redoutable éléphantiasis (Barbadoes bone, Yamsfoot) tellement répandues dans les Antilles danoises, surtout à Ste. Croix, que le dernier récensement, celui de 1901, qui certainement pèche par défaut, porte à 343 le nombre des malades éléphantiasiques dont 333 résidant à Ste. Croix. St. Jan, que les récensements donnent pour exempt d'éléphantiasis, a au moins deux malades de ce genre, que j'ai vus.

Les infirmeries des plantages furent parmi les bâtisses que les nègres démolirent les premières lors des troubles de 1848, parce qu'elles avaient une annexe, épouvantail des noirs, le „lock up room„ dans lequel les esclaves fainéants étaient enfermés depuis le samedi soir jusqu'au lundi matin quand ils n'avaient pas assez travaillé durant la semaine écoulée.

Quand l'esclavage fut aboli, les planteurs ne purent pas songer à rebâtir les infirmeries de plantage, car les nègres ne se laissaient pas interner et l'on n'était pas en état de les y forcer[1]).

Les médecins durent alors, au lieu de visiter les patients à l'hôpital les aller trouver dans le village des nègres et, si l'on recommandait aux „pieds ulcérés“, de se tenir tranquilles dans leurs cases, on pouvait bien compter, qu'aussitôt les autres noirs partis pour leur travail, les malades iraient en visite chez les autres „pieds ulcérés“ du plantage, quitte à faire attention d'être toujours rentrés lorsque les nègres sains reviendraient de leur besogne, car autrement ils seraient découverts par le surveillant („Overseer).

Alors le conseil municipal décida que pour parer à ces inconvénients, on éleverait près de la maison d'arrêt de Richmond un bâtiment destiné à ce genre de patients.

A l'origine les deux sexes habitaient sous même toit; mais on ne tarda pas à constater que ce dispositif avait des inconvénients palpables; un prêtre anglais M. Ahlmann les fit ressortir et les femmes furent alors isolées dans une maison à part contiguë à l'établissement. Les excès recommençant aussitôt et de plus belle, on retransporta les femmes dans l'ancien bâtiment et leur donna le premier étage au-dessus des cellules des aliénés. De nos jours encore il y a là une petite section pour les femmes, bien que celles qui ont des plaies aux pieds soint d'ailleurs traitées à l'hôpital de Peters Farm. Dès 1871 la promiscuité résultant de cet état avait été dénonciée par les plaintes

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1) Aagaard: Rapport à la Commission de la maison d'arrêt de Christiansted 1871, 7 Août.

du médecin en chef Aagaard. Lors de ma visite à cet établissement je trouvai dans la section en question une jeune femme, venant du dépòt de mendicité, atteinte de syphilis, sans nez, aveugle et bien que son état dût être considéré comme inspirant de l'horreur à tout homme sain, elle était la mère d'un enfant qu'assise elle allaitait en ce moment. Quel était le père de cet enfant? Un des surveillants de l'établissement. . . .

Sur le même palier que les femmes logeait un aliéné, le planteur B. Il occupait la chambre du médecin, l'un des meilleurs recoins de cette bauge. La nuit ce planteur à cervelle dérangée pénètre chez les femmes pour satisfaire ses appétits. Ceci se passe dans la section officiellement destinée aux aliénés en convalescence.

Il semble que j'ai suffisamment fait ressortir la pressante nécessité d'éloigner de Richmond les aliénés et de les commettre, par exemple, à l'hôpital communal de Peters Farm, dans lequel on devra alors établir une section spéciale pour les fous qui sera mise au niveau des circonstances.

La lèpre dans les autres Antilles.

Antilles anglaises.

Je rapporte ci-dessous les résultats relatifs aux autres îles et fournis par les rapports insérés dans le compte-rendu de la conférence de Berlin en 1897.

Trinité:

1871:	102 malades	. . . 0,93 %
1881:	149 „	. . . 0,97 %
1891:	225 „	. . . 1,18 %.

Sur ces 225 37,78 % étaient indigènes, 43,56 % hindous.

Les nombres cités semblent indiquer une augmentation de la maladie. Ce que je sais de l'état des choses à la Trinité, visitée par la Commission danoise des Antilles, m'empêche de trop m'appuyer sur cette proportion. Mais ce dont je suis certain, c'est qu'à la Trinité la lèpre est beaucoup, beaucoup plus repandue que ne le présume le gouvernement colonial. En effet, on se contente d'interner dans la léproserie de Cocorite (Surintendant médical le Dr. Knaggs), les lépreux vagabonds et les malades du dépôt de mendicité, tandis que, hors de là, dans les circonscriptions rurales vivent des bandes sans nombre de misérables encore en état de poursuivre de leurs propres forces la lutte pour l'existence. Au Ier Avril 1902 l'asile de Cocorite avait un total de 305 malades (233 hommes et 72 femmes). Cette proportion suffit à montrer que jusqu'ici un grand nombre de femmes se sont soustraites à l'internement. Le surintendant réclame sans cesse un agrandissement.

Grenade (visitée par la Commission danoise):

1881: 3 cas,
1881: 21 „ (14 hommes, 7 femmes — soit 4 ‰ de la population).

Barbades:

1871:	96 cas,	
1881:	108 „	
1891:	156 „	

Il y avait en 1891 114 malades dans l'asile.

St. Vincent:

	1881:	57 cas,
	1891:	62 „ (38 hommes, 24 femmes).
L'asile avait en:	1867:	19 patients,
	1894:	23 „

On est d'avis que la maladie ne fait pas de progrès.

Ste. Lucie:

1891: 32 cas.

Iles sous le vent:

1891: 172 cas (88 hommes et 24 femmes),

dont 129 sont forcés d'habiter l'asile. Sur ce nombre 98 se trouvaient à St. Kitts et 45 à Antigua. On dit que la lèpre fait des progrès à St. Kitts:

1872:	72 cas,	
1890:	120 „	(C. H. Boon.)

L'asile de St. Kitts (St. Christophe) est situé au Sandy Point (Surintendant médical le Dr. Foreman). (Visité par la Commision danoise.)

Les Antilles anglaises ont toutes actuellement une législation spéciale, qui ne se contente pas de prescrire aux lépreux mendiants et vagabonds un isolement, que les circonstances peuvent rendre obligatoire; elle détermine en outre les pénalités encourues par qui introduit aux colonies de nouveaux immigrants malades:

Jamaïque,	loi	d'isolement:	19	Avril	1896,
Barbades,	„	„		-	1890,
St. Kitts-Nevis,	„	„	30	Oct.	1890,
Antigua,	„	„	16	Mai	1896,
Trinité-Tobago,	„	„	3	Mars	1890.

Ces lois dont on peut voir le texte dans les „Mitteilungen und Verhandlungen der I. Leprakonferenz, Berlin 1897" (p. 208—223) contiennent ce qui suit:

1. Règles pour l'établissement de léproseries.
2. Règles pour la nomination de fonctionnaires.
3. Règles pour l'internement des malades (au besoin l'internement obligatoire de malades incapables de s'entretenir — l'internement gratuit de malades indigents — l'internement de malades des classes aisées sur leur demande et moyennant paiement, en général de 2 sh. par jour).
4. Décisions visant à réprimer le goût des lépreux pour le vagabondage.

5. Décisions d'après lesquelles les lépreux qui désirent quitter leur hospice, bien que le médecin s'y oppose, sont mis en liberté moyennant de 20 à 50 Lstr. servant de garantie que le malade peut se nourrir et se soigner.

6. Peines dont sont passibles les lépreux (ou ceux qui occupent des ouvriers lépreux) préparant des aliments ou boissons pour les vendre.

Défense d'employer des lépreux à certains travaux — comme barbiers, blanchisseurs, ouvriers en tabac, brocanteurs ou maîtres d'école.

7. Châtiment des intrus pris sur le terrain de la léproserie, sans autorisation.

8. Décisions relatives à l'arrestation des lépreux qui s'échappent et à la punition des évadés.

A quoi il faut ajouter pour St. Kitts-Nevis:

9. Décisions interdisant aux personnes contaminées de débarquer aux îles, et ordonnant leur rembarquement sur le même navire, le capitaine de ce navire étant frappé d'une amende de 10 Lstr. pour avoir introduit un lépreux dans les îles.

Ces mesures coercitives sont naturellement très bonnes pour les îles auxquelles elles s'appliquent. Quant aux îles qui, comme les danoises, manquent d'une législation relative à l'isolement, ces mesures anglaises auront l'effet contraire, car il va de soi que les lépreux n'attendront pas que leur mal soit trop manifeste, pour chercher à quitter un pays où l'on veut les forcer, et à gagner des parages plus favorables, où ils pourront satisfaire leurs tendances au vagabondage et à la mendicité. J'ai déjà, en 1898, attiré sur cet état de choses l'attention du gouvernement colonial.

Parmi les malades que j'ai examinés dans les Antilles danoises, il y en avaint 12, émigré des autres îles.

No. 1 émigra en 1863 des Barbades,
No. 14 „ 1890 „ .
No. 15 „ enfant, de St. Kitts,
No. 27 „ en 1893 de la Guadeloupe,
No. 34 „ 1903 des Barbades,
No. 84 „ 1867 d'Antigua,
No. 92 „ 1867 de la Trinité,
No. 96 „ de Tortola,
No. 99 „ 1860 de St. Kitts,
No. 104 „ 1898 „
No. 113 „ 1861 de Nevis,
No. 118 „ 1861 des Barbades.

Eu égard à ce qui précède, j'ai recommandé avant tout à l'honorable Commission danoise des Antilles d'agir pour faire interdire aux lépreux l'accès des îles.

Et immédiatement après j'ai attiré l'attention sur le fait que, le 3 Mai 1898 la femme portée sous le No. 77 sur la liste officielle des lépreux a obtenu un passe-port pour se rendre aux Barbades. C'est à peine si l'on devrait permettre chose pareille.

Antilles françaises.

Pour mieux me renseigner sur l'état des choses aux îles françaises, je m'adressai au Dr. A. Kermorgant, Inspecteur général du service de la Santé publique au Ministère des colonies françaises. Voici ce qu'il m'a répondu le 7 Juin 1903 avec beaucoup d'amabilité:

„Je regrette vivement de ne pas être à même de vous fournir les renseignements que vous désirez concernant les lépreux des Antilles françaises. Il m'a toujours été impossible d'obtenir qu'on procédât à un dénombrement, de sorte que je ne puis savoir si la maladie est en progrès ou perd du terrain.

L'an 1897 je fis porter la lèpre sur la liste des maladies devenues l'objet d'une mention obligatoire, mais je ne sache pas qu'un seul cas ait été rapporté. Cette réserve des médecins, quand il s'agit de pareilles dénonciations, ne peut pas nous surpendre; car, s'ils dénonçaient les lépreux, ils seraient sûrs. de perdre leur clientèle.

Les conseils de santé des deux colonies (Guadeloupe et Martinique) ont en différentes occasions exprimé le désir qu'on fit des perquisitions parmi les lépreux; mais les autorités civiles n'ont jamais eu égard à ces désirs.

Des renseignements que j'ai reçus de la Martinique il y a deux mois, il ressort que les lépreux sont en très petit nombre dans la capitale, Fort de France, mais qu'ils sont assez nombreux dans la localité dite la Trinité. Toute-fois on ne peut pas attacher trop d'importance à ces indications; car il s'agit exclusivement ici de patients, dont la maladie peut se diagnostiquer au premier coup d'oeil. Quant à la Guadeloupe, le chef du Département de la Santé dit dans son dernier rapport, que les classes aisées de la société fournissent un assez fort contingent de cas.

En toutes circonstances il est difficile d'arriver à quelque chose de certain; car les malades de bonnes familles, chez qui la lèpre est bien accentuée, se cachent ou bien leur entourage les dérobe aux regards, par crainte qu'on les envoie à la léproserie de la Désirade. C'est pourquoi cet établissement ne sert de réfuge qu'à de misérables êtres privés de tout secours et sans famille.

Léproserie de la Désirade.

„Cet hospice est situé dans une petite île à 6 milles de la Guadeloupe; il date de 1728 et est destinée à recevoir les lépreux de la Martinique et de la Guadeloupe.

La Désirade a 2 lieues de longueur et une de largeur; son point culminant est un plateau dont l'altitude est de 278 mètres.

La léproserie a subi les nombreux caprices du destin; pendant l'occupation anglaise, personne dans l'île ne s'occupa plus des lépreux et quelques-uns d'entre eux s'enfuirent à la Guadeloupe, d'où pourtant on les renvoya plus tard à la Désirade. En 1829 on y bâtit un véritable hospice, encore aujourd'hui debout; c'était une entreprise de particuliers qui avaient fait savoir qu'ils guériraient les lépreux à l'aide de bains et de fumigations.

L'expansion de cet asile est récente.

Sous le rapport des internements les livres de la léproserie signalent:

	un nombre d'internements	de décès
de 1800 à 1850 . .	91	—
de 1850 à 1857 . .	236	175
de 1860 à 1867 . .	255	315

En 1800 une seule personne y entra; en 1847 10; en 1848 7. Depuis 1847 les nombres augmentent.

Sous la révolution, pendant l'occupation anglaise, et quand la France reprit la Guadeloupe en 1814, la léproserie subit naturellement de plus ou moins grandes modifications, mais elles ne laissèrent pas de traces. A l'époque où les malades avaient la liberté de rester ensemble jour et nuit, à leur gré, les naissances étaient assez fréquentes dans la léproserie. On rapporte:

de 1827 à 1834 . . . . 5 naissances,
de 1834 à 1857 . . . . 28 „

Presque tous ces enfants vinrent au monde sans trace de la maladie de leurs parents.

La mortalité varie avec les années et tient à différentes causes. En 1887 il y eut 60 malades des deux sexes, dont 6 moururent, surtout des gens âgés. De 1865 à 1866, 20 des 120 malades moururent, surtout du choléra qui, cette année-là fit beaucoup de victimes dans l'île. Les 60 malades de 1887 étaient

3 blancs atteints de cancer,
26 hindous,
31 créoles, nègres ou mulâtres,

soit 45 hommes et 15 femmes, dont deux blanches.

D'après une autre statistique de 1891 il y avait alors 56 patients en traitement à la Désirade:

	Par races:
13 hommes,	10 nègres,
17 femmes,	21 mulâtres,
1 petit garçon.	22 hindous,
	3 blancs.

Une négresse de 75 ans fut internée avant 1855,
„ „ „ 66 „ „ „ „ 1867,
un nègre „ 66 „ „ „ „ 1856,
une négresse „ 80 „ „ „ „ 1864.

Cette dernière mourut de vieillesse en 1895, le nègre en 1896 d'une broncho-pneumonie subaiguë.

La pentade de 1891 à Janvier 1896 a vu entrer 32 hommes et 9 femmes, en tout 41 et mourir 30 hommes et 10 femmes, soit 40 en tout. La mort a frappé les plus âgés.

Je regrette de ne pas pouvoir vous donner des renseignements plus exacts; comme je l'ai dit plus haut, les familles d'une certaine aisance gardent leurs malades et les cachent soigneusement. D'autre part les conseils municipaux de la Guadeloupe et de la Martinique ont souvent envoyé à la léproserie de la Désirade des indigents

couverts de plaies, mais qui n'étaient nullement lépreux, l'idée étant simplement de se débarasser de ces malades. Ainsi en 1897 il y avait 3 cancéreux. En outre on a aussi envoyé audit établissement des nègres ayant aux pieds des plaies causées par le pulex pénétrant, parce qu'ils avaient perdu les orteils et qu'à tort on les avait cru lépreux.

Pour le moment la léproserie est dirigée par un officier de santé assisté par des religieuses.

Agréez etc. A. Kermorgant.

Antilles ci-devant espagnoles.

Les lépreux y fourmillent. Les nombres se révèlent au fur et à mesure que les Américains commencent à déblayer l'état des choses.

Cuba a fourni plusieurs rapports dont le plus explicite est celui de Robelin.[1]) D'après cet auteur il y a

dans l'hôpital St. Lazare de la Havane	117	lépreux,
„ „ „ „ „ Santa Clara	25	„
vivant en liberté dans la province de Pinar del Rio . .	275	„
„ „ „ „ „ „ „ Puerto Principe .	250	„
„ „ „ „ „ „ „ Santa Clara . .	120	„
„ „ „ „ „ „ „ Santiago de Cuba	40	„
en tout	1297	lépreux,

soit 1,13 par mille. On ne saurait en douter, le nombre réel est beaucoup plus grand. A Porto Rico aussi l'on a commencé à découvrir des lépreux[2]); jusqu'ici le nombre est petit, mais on ne tardera pas à en trouver bien davantage. On se borne en attendant à porter le total à une soixantaine. On a établi une léproserie au prix de 2869 Doll. en refaisant les constructions déjà existantes, en l'Isle de cabras dans la rade de San Juan. Provisoirement il y a place pour 17 personnes.

A l'appui de la loi concernant l'isolation.

Cours de la maladie.[3])

La lèpre est une maladie contagieuse qui se manifeste par la formation de petites nodosités ou de petites enflures de consistance gommeuse, ne dépassant pas en général la grosseur d'un pois ou d'une noisette, n'importe où sur le corps. Ces nodosités sont dues à un bacille particulier à la maladie et découvert en 1869—1874 par Armauer Hansen, aujourd'hui encore médecin en chef pour la lèpre en Norvège. Cette maladie est remarquable par l'extrême longueur de sa période d'incubation; c'est-à-dire qu'il s'écoule beaucoup de temps, souvent assurément plusieurs années entre le moment où la contagion est transmise à l'organisme par des voies que nous ne connaissons pas encore, et l'apparition des premiers symptômes. Fréquemment même il se passe beaucoup de temps, peut-être même des années

1) Revista de medecina tropical. Habana, Marzo 1902, p. 39.
2) First report of Governor Allen. Washington 1901, p. 52.
3) Extrait de Ehlers, "La Lèpre", Copenhague 1895. Nordiske Forlag, med 18 illustr.

avant que ces symptômes deviennent assez alarmants pour être bien saisis.

Les premiers symptômes, les prodròmes, sont en effet d'une nature assez commune: accès de malaise général, migraine, épistaxis, sécheresse du nez, accès de vertige, douleurs et inquiétudes dans les membres, auxquelles on applique par légéreté le nom de „rhumatismes“ pour trancher la question.

C'est là ce qui rend très difficile d'aller au fond des choses pour trouver la piste d'une contamination; car quand la maladie se déclare chez un patient, le malade qui lui a donné la maladie, est peut-être déjà mort ou loin.

La lèpre attaque de préférence la peau ou les nerfs; c'est d'après cela qu'on distingue ses deux formes, la forme tubéreuse et la forme nerveuse.

La forme tubéreuse se révèle par de petites nodosités dans ou sous la peau; le premier siège est ordinairement les sourcils; ils tombent, puis autour des articulations des mains et des pieds, et plus tard partout sur le corps entier. Mais la toute première ligne d'attaque est le visage; il se dépare, devient méconnaissable, se couvre de tubérosités qui, à une phase plus avancée, donnent à la face un cachet particulier, désigné par le terme de facies léonin. Un autre point des premiers attaqués est aussi l'intérieur du nez: il s'obstrue de boutons et de plaies, puis le pharynx et le larynx, qui peu à peu se remplissent de nodosités rendant la voix rauque et sans timbre. Ces mêmes causes rendent l'haleine puante. La maladie tombe fréquemment au début des premières années sur les yeux et rend aveugle. Les boutons s'épanouissent pour former de larges plaies ou disparaître; mais on voit périodiquement surgir de nouvelles nodosités et, au bout de quelques années, de 2 à 8 ans, pendant lesquelles le malade ne cesse de souffrir de plus en plus, il succombe à l'invasion générale de ces nodosités, qui vraisemblablement sont capables de détruire le tissu des poumons et devenir ainsi la cause de la mort.

Dans le type lisse la formation des nodosités reste latente dans les troncs nerveux, surtout dans le nerf ulnaire et le nerf péronéen, mais elle a lieu également dans les autres troncs nerveux des quatre membres. En se formant dans les troncs nerveux ces nodosités causent de terribles douleurs et anéantissent les fonctions des nerfs, tout d'abord la sensibilité, à l'apparition de grandes taches anesthésiques, puis aussi la motilité par atrophie musculaire et paralysies. Le premier symptôme de cette maladie est donc souvent la présence de taches insensibles, que le patient découvre tout à fait par hasard. Les muscles, devenus incapables de mouvement, s'atrophient et se réduisent à rien. Les premiers groupes, attaqués dès le commencement, sont ceux de la main, spécialement du pouce.

En conséquence de l'atrophie musculaire les membres, doigts ou orteils en question, se contractent, certains groupes de muscles gagnant le dessus des autres: les doigts deviennent crochus et se replient tout à fait dans la main, de sorte que les ongles parviennent à creuser de profondes plaies dans la paume et les mains se transforment en griffes émoussées. — Mais la perte de la sensibilité suscite des lésions tout autrement sérieuses. A mesure que la sensibilité s'éteint, le malade

s'attire, sans en avoir conscience, toute espèce de détériorations, spécialement dues aux brûlures, piqûres d'objets envenimés, p. ex. clous rouillés, arêtes de poisson ou analogues. Ce n'est que longtemps après l'accident, que le malade s'aperçoit, s'il est encore en état de voir, que la plante de son pied est devenue le siège d'une large plaie, fort malpropre, qui avance en rongeant jusqu'à l'os; ou bien c'est un panaris au doigt et l'inflammation atteint généralement l'articulation des phalanges, provoque une ostëite et détâche les phalanges, ceux-ci finissant par tomber. C'est ainsi que s'en vont les doigts, l'un après l'autre, accidents que les Islandais dépeignent très bien par la terme de Limafallssyki (maladie de la chûte des membres) et il ne reste plus qu'un affreux moignon informe. Une conséquence de l'insensibilité de la cornée est la facilité avec laquelle la poussière et la saleté s'attachent à la cornée, sans que le malade s'aperçoive qu'il est entré quelque chose dans son oeil; l'inflammation suscitée de la sorte est souvent cause que dès les premières années de la maladie la vue est perdue.

C'est à peu près ainsi que se présentent les deux formes principales, mais l'un et l'autre peuvent frapper simultanément le même malade, bien qu'en général la maladie s'en tienne à l'une ou à l'autre forme. De temps à autre il arrive que la forme tubéreuse passe à la forme anesthésique et que toutes les nodosités s'effacent; au contraire il est beaucoup plus rare que des nodosités fassent apparition à la peau durant l'évolution de la forme anesthésique.

Ces deux formes mettent un temps très différent à évoluer; la tubéreuse amène volontiers la mort au bout d'une dizaine d'années au plus, mais la forme anesthésique peut traîner des vingt ans et plus.

Projet d'une loi sur la lèpre pour les Antilles danoises,

> Motto: Je conseille que lorsqu'on les voudra séparer, on le face le plus doucement et amiablement qu'il sera possible ayant mémoire qu'ils sont semblables à nous: ou il plairait à Dieu, nous serions touchéz de semblable maladie, voire encore plus griefve. Et les faut admonester que, combien qu'ils soient séparez du monde, toutesfois ils sont aimez de Dieu, en portans patiemment leur croix. (Oeuvres d'Ambroise Paré, p. 545.)

§ 1. La lèpre est une maladie chronique, contagieuse. Chaque cas doit être déclaré à l'inspecteur médical. Les décès parmi les lépreux doivent être déclarés de la même manière. Chaque année l'inspecteur médical dresse un rapport spécial sur cette maladie au Collège Royal de Santé. Le devoir de ces déclarations incombe aussi bien aux médecins qu'aux propriétaires de plantages.

Est déclaré passible d'amende quiconque néglige de signaler les cas.

§ 2. Il sera établie une colonie de 50 malades à . . . . . .[1])

§ 3. On devra transporter à la colonie, par force s'il le faut, les lépreux commis aux soins du dépôt de mendicité, ainsi que les malades qui se rendent coupables de vagabondage ou de mendicité, et en outre, les personnes qui, bien qu'en état de s'entretenir, vivent dans un milieu et dans des conditions telles que le conseil sanitaire du lieu n'y trouve rien de rassurant au point de vue du danger de contamination. La question de décider si telle personne est atteinte de la lèpre, est vidée par l'inspecteur médical de concert avec le médecin public. Dans les cas douteux ils s'adjoindront un troisième médecin parmi ceux de l'île.

§ 4. Toute personne frappée de lèpre a le droit de réclamer son internement dans la colonie des lépreux.

§ 5. Une fois admis dans la colonie les patients seront tenus d'y rester jusqu'à ce que le médecin de la colonie certifie que la maladie est en voie de guérison ou a passé dans un stade non-contagieux. Toute évasion de la colonie sera punie d'emprisonnement dans l'enceinte de cette même colonie.

§ 6. Les lépreux qui vivent hors de la colonie, ne doivent vendre aucun article servant à la nourriture; ni rien préparer de ce qui tient à l'alimentation. Les lépreux ne doivent faire les fonctions ni de médecins, ni de pharmaciens, ni d'accoucheurs, ni de barbiers. Les lépreux ne doivent fonctionner ni comme vendeurs ni comme expéditeurs. Tout délinquant sera, de force, mis dans la colonie.

§ 7. Il n'est pas permis aux lépreux de débarquer aux Antilles danoises. De tels passagers sont renvoyés au port d'où ils viennent, par le bâteau qui les a apportés ou pour le compte de l'armateur responsable. Tout capitaine qui transporte aux îles un lepreux, est passible d'une amende de 50 Doll.

Il ne sera pas délivré de passe-port aux lépreux qui veulent sortir des îles.

§ 8. Les lépreux vivant hors de l'asile, auront leur literie à eux, leur batterie de cuisine à eux et leur couvert à eux. Le linge des lépreux, leurs vêtements de dessous et autres articles d'habillement seront lavés à part sans contact avec les autres objets du ménage. Les ustensiles de cuisine et le service de table seront également nettoyés à part. Chaque lépreux aura son crachoir à lui et nul ne devra cracher à terre. Aucun lépreux ne soignera les enfants ni les malades, ni ne préparera la nourriture d'autrui. Sauf le cas de nécessité urgente nul lépreux ne doit faire de visite aux étrangers, moins encore s'annuiter chez eux; s'il est chez lui, il n'y recevra de visites qu'en cas d'urgence. L'inspecteur médical peut, de concert avec le médecin publique, imposer à ces malades un règlement de précautions visant à garder leur entourage contre la contagion.

En cas d'infraction le malade peut être interné de force dans la colonie.

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1) J'ai proposé une des presqu'îles ci-dessous comme lieu convenable: Shoys, Judiths Fancy ou Hams Bau, toutes localités situées en Ste. Croix, qui est le centre de ralliement des lépreux et où l'on doit amener les malades de St. Thomas.

§ 9. Au-dessous de 15 ans les enfants dont le père ou la mère ont la lèpre, seront élevés en dehors du ménage lépreux.

§ 10. Toute affaire litigieuse concernant la question de la lèpre sera réglée par le conseil de santé du lieu, mais on pourra en appeller au Collège Royal de Santé à Copenhague.

La Colonie des lépreux.

Loi d'isolement et défense d'immigrer ne suffisent point. Il faut procurer aux lépreux un séjour plus convenable que l'asile actuel. A l'époque actuelle nous sommes en droit d'élever les prétentions un peu plus grandes qu'au moyen-âge; en ces temps-là on tenait les lépreux sequestrés jusqu'à leur mort, moins dans leur propre intérêt que pour écarter de la société le danger de la contagion. Mais de nos jours nous avons l'espoir de pouvoir réaliser quelque chose en soumettant les lépreux à un traitement et à des soins, surtout dans le magnifique climat des tropiques où, bien qu'entièrement abandonnée à elle-même comme elle l'est aujourd'hui, la lèpre a déjà une évolution bien plus lente et bien plus bénigne qu'en Scandinavie. Mes observations me permettent d'exhiber un certain nombre de cas qu'on peut à bon droit considérer comme guérisons. Pourquoi la lèpre serait-elle incurable?

Il y a 20 ans la tuberculose, cette soeur de la lèpre, ne passait-elle pas pour maladie incurable? Le diagnostic „Tuberculose" résonnait alors comme une sentence de mort. Aujourd'hui nous avons tellement agrandi le cercle de nos connaisances concernant les types bénins de cette maladie, que nous savons ces types-là guérissables. Il faut espérer que quand nous connaîtrons mieux les formes les plus bénignes de la lèpre nous obtiendrons de pareils résultats, à notre joie.

Car, en ce qui concerne la lèpre les médecins d'Europe se sont trop laissé effrayer par les idées enracinées chez nos ancêtres sur l'incurabilité de la maladie et l'on est resté stationnaire en face des faits constatés par Danielssen et Boeck relatifs au cours pernicieux de ce mal dans les zônes contiguës.

Nous devons espérer que le XXme siècle nous fournira les moyens nécessaires au traitement des lépreux, qui jusqu'ici par pauvreté et par manque de soin vivaient sous la belle étoile. Que le lépreux soit arraché à son intérieur pauvre; qu'on lui épargne la dure lutte de l'existence, lui fournisse la nourriture, le vêtement et ce qu'il faut pour le panser, qu'il soit traité à l'aide de bains et de médicaments convenables; cela suffira pour produire sur la maladie un effet surprenant. Les plaies se cicatrisent, les éruptions diminuent de violence et la maladie tend à passer à la forme nerveuse plus bénigne et plus traînante, dont la dernière phase, la lèpre anesthésique pure est considérée comme forme guérie, par nombre d'auteurs, entre autres Armauer Hansen, qui a découvert le bacille de la lèpre.

D'ailleurs la localisation des éruptions de la lèpre et leur caractère font déjà ressortir, que nous sommes fondés à espérer la découverte de moyens capables de guérir cette maladie; car les accidents locaux peuvent même pour les formes les moins maniables, disparaître avec restitution locale ad integrum. Les altérations anatomo-patho-

logiques de la maladie montrent une tendance à une cicatrisation locale identique à celle que nous présentent la tuberculose et la syphilis. Et l'on ne saurait supposer qu'une différence du degré dans cette tendance à la guérison de la maladie généralisée et de la maladie localisée.

C'est encore là un grand motif pour rendre urgente la question d'établir une léproserie au niveau de notre époque. J'ai déjà insinué que cet établissement doit préférablement avoir le caractère d'une colonie agricole agencée d'après le climat et l'état du budget.

Une léproserie moderne doit offrir aux patients des conditions d'existence telles qu'ils se fassent une joie d'y pouvoir entrer et qu'ils aiment mieux y séjourner au dépens de leur liberté et jouir d'un grand bien-être dans l'enceinte de cet asile, que de vivre indépendants hors de là. L'isolement obligatoire sera réalisé à l'égard des lépreux qui mendient et vagabondent, ainsi que de ceux qui, d'après l'avis de la commission d'hygiène, vivent dans des conditions d'où résulte un danger de contagion pour leur entourage. Mais tout à côté de cela il faut espérer que, bien transplantés dans un entourage qui les satisfait, ayant à leur disposition des travaux et distractions appropriés, et en même temps un bon entretien, de bons traitements, les patients seront tentés de se faire interner, même dans le cas où ils pourraient continuer un peu à lutter pour vivre. Ce bien-être est réellement aussi le plus maigre dédommagement que la société puisse offrir pour le sacrifice de la liberté exigé de ces malheureux. A ce simple point de vue la léproserie de Richmond est une pure impossibilité.

En outre, cet asile de Richmond manque à une des exigences qu'on doit absolument maintenir dans un pareil établissement, savoir : que les sexes y soient complètement séparés. Les trois enfants nés dans la léproserie témoignent assez de l'irrégularité qui y règne en fait d'ordre.

Tandis que sous les cieux boréens l'on est forcé de soigner les lépreux dans des hôpitaux ou asiles, les climats sous-tropicaux permettent de procéder très avantageusement à fonder pour les lépreux des colonies agricoles ou horticoles. En effet les malades ne sont pas absolument incapables de travail; il n'y a là qu'un abaissement de niveau dans la productivité. Mettons qu'un tiers des patients, soit tous ceux de la dernière phase, se trouvent tout à fait hors d'état de travailler; le second tiers pourra temporairement — dans les périodes libres entre les éruptions ou manifestations de la maladie chronique — faire quelque léger travail; le troisième tiers qui, peut-être, a presquerecouvré sa capacité de travail, ne restera qu'un peu en deça du programme. Dans les Antilles danoises beaucoup de lépreux sont employés comme ouvriers de seconde classe, gardent les moutons ou ont des occupations de ce genre dans les plantages, où la superstition vient même à leur aide: „Les bergers sans doigts portent bonheur."

En fondant une colonie agricole de lépreux, on les met à même de porter une partie du fardeau de leur entretien. Il va de soi qu'on est forcé de leur donner une part au rendement du labeur, car autrement on ne saurait porter ceux qui sont relativement capables de travail, à travailler pour leurs compagnons de souffrance mis hors d'état d'agir.

A la Trinité dans l'asile de Cocorite on fait travailler les malades au jardin, dont l'aire a une dizaine d'acres. La récolte sert exclusivement à l'alimentation personnelle des lépreux, et ne doit pas être vendue à qui il ne concerne; mais on en estime la valeur en argent, dont la moitié revient à l'asile et l'autre au malade qui a fait le travail.

Sans doute on pourrait classer les patients de la future colonie de lépreux de Ste. Croix, d'après leurs aptitudes au travail, comme on l'a fait dans les plantages, voir en eux des ouvriers de seconde classe et de troisième classe à demi-paie, soit 5 et 3 cents par jour, respectivement; car, ayant leur entretien complet, ils n'ont pas besoin d'un salaire complet.

Le travail sera un bienfait pour leur misérable existence; il augmentera en eux la transpiration et activera la circulation du sang; suscitera dans leur pensée une satisfaction personnelle, relèvera leur courage et réagira contre les progrès de l'atrophie musculaire.

Quant au choix de l'emplacement pour établir une pareille colonie, il est beaucoup de gens pour qui une île constitue l'ideal d'un parfait isolement. Comme je l'ai déjà dit, les Américains ont récemment agencé en léproscrie l'île aux chèvres (Isla de cabras) près de San Juan de Porto Rico.

Toutefois il y a nombre de motifs qui parlent contre le choix d'une île: Une île n'est pas abordable en tout temps; son avitaillement et l'inspection médicale y dépendent du temps et du vent. Mais il est une autre considération plus importante, celle de l'isolement insulaire: on verra toujours là une île déserte et les pauvres malades ainsi que leurs parents s'en effraieront. Le résultat sera simplement, qu'on n'engagera pas beaucoup de malades à se laisser déporter et l'on aura le triste agrément, que les parents des malades leur prêteront la main et les cacheront aussi longtemps que possible, ce qui augmentera pour leur entourage le danger de la contamination; de plus il y aura des tentatives de fuite, et les patients qu'on aura fini par réussir à isoler, chercheront à s'évader. Il faudra alors en revenir au système pénible et coûteux des perquisitions pour rattraper les fugitifs et les réinterner par force. Tout cela suscite le mauvais vouloir de la population contre l'isolation des lépreux et finit par faire de l'île une île du diable. L'île où Dreyfus fut prisonnier avait précisément été une île à lépreux.

Ces raisons et beaucoup d'autres encore me font conseiller de choisir une des péninsules attenant à Ste. Croix, savoir Shoys, Judiths Fancz ou, faute de mieux Hams Bay.

Quant aux frais d'établissement d'une léproserie, on voudra bien se reporter au devis élaboré de concert par le lieutenant de génie Schouboe, inspecteur des bâtiments, et par moi (prix en tout 12 6000 Doll.).

Aux points susdits il sera aisé de réaliser l'isolement des lépreux: le sol s'y prête à la culture. La distance des villes suffit à isoler les patients, sans toutefois être assez grand pour dégoûter les malades et leurs proches ou pour nécessiter l'installation d'un médecin à demeure dans la colonie. Le médecin de la ville la plus rapprochée pourra faire la visite.

Frais d'entretien des lépreux.

M. Dendtler, ci-devant inspecteur de Richmond estime, comme suit, les dépenses par tête:

Ration quotidienne 16 cts., soit, par an	Doll. 59,40
2 pantalons à 1 Doll.	2,—
2 chemises à 1 Doll.	2,—
1 chapeau	—,20
2 draps à Doll. 1,48	2,96
1 couverture de laine	2,95
matelas et oreiller	1,48
2 gilets à Doll. —,30	—,60
rations extra durant l'année	3,—
chaussure et faux frais	3,—
médecine (médicaments)	3,62
total	Doll. 80.21

Le budget du matériel et de l'habillement pour 1903—1904 a l'aspect que voici:[1])

40 chemises	Doll. 40,—
30 jupes	40,—
20 matelas et oreillers	30,—
20 couvertures de laine . . .	59,—
16 paires de drap	47,36
24 vases de nuit	9,—
36 écuelles en fer blanc . . .	5,04
24 foulards de tête	4,80
36 gilets	10,80
30 cotillons et chemises de femme	32,—
12 balais	4,—
6 brosses à frotter	3,—
12 cadenas	9,—
réparation de vêtements etc. . .	25,—
frais imprévus	20,—
total	Doll. 339,—

Le médecin en chef devient directeur de l'établissement et touche 200 à 300 Doll. d'appointement.

Est attaché à la léproserie un économe ou gérant comptable, qui touche 600 Doll. d'appointement, outre la gratuité du logement et du jardinage.

Le soin des malades sera confié à deux infirmières, salariées de leur entretien gratuit et 200 Doll. chacune. Leur ration quotidienne est estimée à 25 cts. soit 180 Doll. par an pour les deux. Tous les services de domestique incombent au mieux portants des patients.

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[1]) Calculé pour 35 patients.

Devis des frais de gestion.

Appointement du médecin en chef . .	300 dollars
„ „ gérant	600 „
Salaire des deux infirmières	400 „
Entretien des deux infirmières . . .	180 „
Alimentation et entretien de 70 patients à 80 dollars par an et par tête . .	3500 „
total	4980 dollars.

A l'égard de ces frais que l'honorable Commission Royale pourrait bien trouver élevés, il faut remarquer que

1. 37 des lépreux actuellement en vie sont déjà indigents classés et 4 sont tout à fait hors d'état de se nourrir. La majeure partie du reste vit plus ou moins de la charité privée. La lèpre est une maladie qui, fatalement en une dizaine d'années, enlève à sa victime l'aptitude au travail. Tôt ou tard il faut donc que les pouvoirs publics s'occupent des patients.

2. En isolant d'un seul coup 70 des pires et plus contagieux d'entre les malades on prévient l'extension du fléau à d'autres sujets et l'on se crée des bases pour espérer qu'au bout d'un nombre d'années limité, soit une vingtaine ou moins, le mal de la lèpre aura subi l'éradication complète.

La Norvège nous a donné une preuve de ce que peut produire un contrôle réel de la maladie et l'isolation obligatoire suivant les circonstances, à l'instar du moyen-âge.

Durant ces 30 dernières années, grâce à des mesures préventives intelligentes, la lèpre n'a pas cessé de diminuer. Le rapport officiel donne les chiffres suivants:

1856: 2833	1865: 2683	1875: 2125	1885: 1415	1895: 766
1860: 2757	1870: 2527	1880: 1804	1890: 1091	1900: 577.

Le 6 Juin 1885 vit entrer en vigueur une loi prescrivant d'isoler les lépreux de la Norvège et de les interner dans des établissements publics pour les y soigner et guérir. L'effet de cette loi sur la baisse du mal est un sujet de joie, tellement que la Norvège vient de transformer deux des grandes léproseries en hôpitaux pour combattre le fléau de nos jours, la tuberculose, ne conservant qu'une léproserie dans chacune des villes de Bergen et de Trondhjem.

En 1894—1895 je trouvai en Islande 181 lépreux en tout, et exprimai l'opinion qu'il devait y en avoir au moins quelque deux cents. Ma supposition a été pleinement justifiée par les derniers dénombrements officiels. Mes recherches ont eu pour résultat que la loi d'isolation fut édictée le 4 Février 1898 et que cette même année une léproserie fut ouverte à Reikiavik à l'instigation de la section danoise de l'ordre indépendent des Odd Fellows.

Il y a cinq ans seulement que cette loi est en vigueur et voilà que déjà, d'après le dénombrement officiel, le nombre des lépreux a baissé d'un bon quart: il est de 133.

L'argent qu'on dépensera aujourd'hui pour isoler les lépreux, donnera donc de fortes rentes avec les années et il s'agit ici simplement d'un débours, qui diminue d'année en année et cessera au bout de 20 ans au plus.

En dernier lieu il ne faut pas oublier ce que j'ai développé plus haut, savoir la prévision que la catégorie des lépreux capables de travail contribuera par ses produits à diminuer les charges de son entretien.

Italien.

Bericht

von

U. Mantegazza in Cagliari.

Anch' io debbo deplorare, come già aveva fatto il Prof. C. Pellizzari nel rapporto presentato alla conferenza del 1897, che una statistica sicura dei leprosi in Italia non esiste. Questo difetto gravissimo si spiega facilmente quando si pensi al modo come sono fatte le ricerche statistiche sulle singole malattie. In Italia funziona al Ministero dell' Interno una Direzione generale della Sanita pubblica, la quale, tra le altre molteplici cure, ha pure quella della compilazione delle statistiche sanitarie. Essa, per mezzo dei medici provinciali e degli ufficiali sanitari comunali, raccoglie tutti i dati relativi alla morbilità e mortalità nel Regno, ed in base ad essi compila le statistiche relative ad ogni malattia. Ora, è facile comprendere che le cifre ufficiali sulla lepra non saranno mai esatte per la semplice ragione che coloro, i quali devono fare la diagnosi della malattia — salvo rare eccezioni — non sanno, qualche volta neppure grossolanamente, che cosa sia la lepra. A me, per es, è accaduto piu d'una volta, mentre visitavo i paesi di Sardegna, di vedere leprosi dove il medico locale non ne sospettava nemmeno l'esistenza, oppure mi è occorso d' osservare casi di lupus, sifilide, ittiosi, pellagra presentatimi per leprosi.

È mai possibile che statistiche, compilate in tale modo, siano veritiere? No, certamente. Egli è percio che io, senza tenere nessun conto delle cifre ufficiali, m' intratterrò in breve sulle ricerche particolari che sono state fatte dal 1897 ad oggi da alcuni dermatologi con mezzi proprii, indipendentemente da qualunque incarico od aiuto governativo.

I risultati sono stati assai importanti, specialmente in alcune regioni.

Eccoli esposti sommariamente.

Sardegna.

Il Prof. Mazza nel 1897 segnalava al Prof. C. Pellizzari che nella provincia di Cagliari vi saranno stati presumibilmente una ventina di casi.

Nel 1901—1902 io intrapresi, per mio conto, indagini nella parte infestata dell' Isola e pubblicai, nel 1902[1]), un' estesa relazione da cui risultava che in 17. comuni vivevano ben 43 leprosi di cui 22 erano uomini e 21 donne.

Fissai allora i seguenti caratteri generali della lepra sarda.

I. Grande prevalenza delle forme nervose e loro lunghissima durata (L. nervosa 25, mista 10, tuberosa 8).

Presenza di non poche forme fruste, rappresentate da leggiere atrofie muscolari, circoscritte anestesie, e di alcune forme coi sintomi della malattia del Morvan della sclerodattilia, dell' atrofia muscolare progressiva tipo Duchenne-Aran, dell' ainhum.

II. Relativa benignità delle forme tubercolari e loro facile trasformazione in quelle miste, con prevalenza dei sintomi nervosi ed attenuazione delle localizzazioni tuberose.

III. Nessun fatto sicuro in favore dell' ereditarietà, molti invece per la contagiosita (servitore che preude la malattia dalla padrona leprosa, marito con una forma nervosa che trasmette alla moglie una lepra tubercolare, individui (14) che si ammalano senza aver avuto nessun precedente ereditario, nè in linea acsendente nè collaterale).

IV. Nessun rapporto tra lepra e malaria.

V. Probabile entrata del virus leproso per le cavità nasali e per i piedi.

Nel luglio 1904 mi recai di nuovo a far un giro nei paesi infetti per constatare lo stato dei malati gia visti e ricercarne eventualmente dei nuovi.

Degli ammalati vecchi, 7 sono morti, nel periodo di due anni circa. Di essi, 4 erano affetti da L. tubercolore, uno da L. mista e due da L. nervosa. Notiamo subito il fatto della grande mortalità nei casi di L. tubercolare (4 sopra 8) in confronto dei casi di L. mista (1 sopra 10) e L. nervosa (2 sopra 25); mortalità che si spiega facilmente sol che si pensi alle condizioni gravi, e quindi, alla minore resistenza in cui si trovano i leprosi tuberosi di fronte alle comuni malattie. Difatti i nostri malati sono tutti morti in un epidemia d'influenza per polmonite.

I malati nuovi sono complessivamente 15 (nomini 12, donne 3). I leprosi morti da un anno circa, non registrati nella prima relazione, sono 4.

Dei leprosi vivi, 9 sono affetti da forme tubercolari gia avanzate, 4 da forme nervose e due presentano soltanto i sintomi iniziali (epistassi rinite, eritemi alla faccia ed agli arti, febbre, dolori reumatoidi etc.).

In un solo paese vivono 7 dei suddetti leprosi: tutti gli altri sono sparsi in altri 6 paesi in cui gia esistono altri malati.

Meritevoli di menzione sono le notizie che ho raccolto in un paese sopra una famiglia di leprosi, di cui ora non è superstite che una sola rappresentante.

Da madre leprosa, ora morta, e da padre tuttora vivente e sano nacquero tre figli; il primo, venuto alla luce quando la madre era da poco tempo malata, ebbe i primi sintomi dopo i 20 anni e mor di lepra a 38.

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1) Mantegazza, U., La lepra nella provincia di Cagliari. Firenze Tipografia L. Niccolai 1902.

Nel secondo pure maschio, nato nel periodo piu critico della malattia materna, la lepra assunse la forma tubercolare piu grave che nel primo ed uccise il malato a 25 anni.

Nel terzo, una ragazza di 20 anni sempre viva in buone condizioni, la malattia si manifestò e si mantenne sempre coi caratteri di una forma nervosa relativamente benigna (atrofie muscolari delle mani ed avambracci, sclerodattilia, mal perforante plantare).

Il fatto importante che riguarda codesti tre leprosi è questo, che gli ultimi due sarebbero nati gia coi sintomi di lepra.

Se questo fosse vero, avremmo un argomento di non poco valore per supporre una trasmissionne ereditaria. Notiamo, però, che noi stessi non abbiamo constatato i sintomi leprosi dei neonati, e le dichiarazioni fatteci, in proposito, dai parenti, hanno, per noi, un valore molto relativo. Malgrado questi dubbii, non possiamo escludere a priori che eccezionalmente in una donna, nel fiore della lepra, si sviluppino alterazioni placentari, per le quali il virus, come avviene per la sifilide, passi dalla madre al feto e dia luogo a sintomi che già si possono rivelare alla nascita. Ho detto eccezionalmente perchè la clinica ci ha dimostrato come i figli dei leprosi nascano, si puo dire sempre, sani e si ammalino, in generale dopo i tre anni, quando non si puo eliminare il dubbio del contagio materno o paterno.

Anch' io recentemente ho avuto occasione di visitare due figli di donne con lepra tubercolare, l'uno di 2 anni, l'altro di pochi mesi, ambedue senza alcun sospetto di lepra. Ora se codesti bambini diventeranno leprosi, è pin logico ammettere che l'infezione è stata trasmessa per contagio e non per eredità.

Nelle ultime ricerche mi sono preoccupato d' investigare se mai qualcuno dei leprosi si fosse fatto centro di diffusione della malattia ad altri membri della famiglia o ad estranei. Pur troppo le indagini non sono state infruttuose. Un nomo di 23 anni si presenta con una lepra tuberosa di 3 anni, contratta con tutta probabilità dal padre affetto da una forma gravissima. Notisi che la madre è viva e perfettamente sana. Un giovanetto di 16 anni robustissimo, annunzia i primi sintomi della malattia (eritemi, intasamento nasale, ipoestesie ete.) la quale certamente ha la sua origine dalla madre morta leprosa da pochi anni. Il padre vive ed è sanissimo. Un altro giovane di 14 anni ha pure una lepra incipiente, che deve rimontare al padre morto 5 anni fa della stessa malattia. Anchi qui la madre è perfettamente sana.

Nel 1° e 3° caso il contagio è certo, perchè non è ammissibile una trasmissione germinativa paterna senza infezione della madre.

Nel 2° caso neppure si puo ritenere probabile l'ereditarietà materna, dal momento che la malattia nel figlio è comparsa dopo 15 anni dalla nascita.

Per fortuna non sono tanto comuni tali casi disgraziati di contagio. Ho riveduto difatti, dopo due anni, molti altri leprosi convivent in famiglia con parenti di tutte le età e nella piu intima promiscuità senza che abbiano contagiato nessuno.

Quale è il pronostico della lepra sarda dal punto di vista epidemiologico? Si estinguerà presto? E' un fatto che dopo due anni i

casi nuovi, comparsi in questo periodo di tempo, sono inferiori a quelli morti. Se si mantenesse costantemente anche in seguito una tale proporzione potremmo stare tranquilli che la morte, da sola, libererebbe fra non molto il paese da cosi brutta malattia. Pur troppo non possiamo essere cosi ottimisti, perchè, pur trascurando che altri nuovi casi possono essere sfuggiti alle nostre indagini, non dobbiamo dimenticare che se il virus ha avuto tanta tenacia da resistere per tanti secoli fino ad oggi, è necessario ammettere che nella vita del bacillo, per cause che noi non conosciamo bene, vi siano dei periodi di maggiore rinvigorimento e virulenza, duraute i quali la malattia puo diffondersi con ridestata energia attaccando maggior numero di vittime. Ecco perchè non ci è permesso assistere inerti all' evolversi della lepra, aspettando la desiderata estinzione spontanea, ma c' incombe il dovere sacrosanto di combatterla energicamente con tutti i mezzi che l' igiene moderna ci consiglia.

Sicilia.

Gia il Prof. C. Pellizari ha accennato alle ricerche fatte dal Profeta e Ferrari sui leprosi di Sicilia. Ricorderò ora appena che il Profeta fin dal 1867—68 pubblicò alcune osservazioni di casi di lepra, nel 1875 segnalò ben 114 casi sparsi in 4 provincie delle 7 che vi sono in Sicilia, nel 1879 fece conoscere altri 30 nuovi casi in focolai ancora ignorati, infine nel 1881 ebbe ad osservare altri due leprosi.

Il Ferrari, che si è occupato specialmente della lepra nella provincia di Catania e Messina, nel 1888 raccolse 39 casi e nel 1893 altri tre.

Complessivamente sono stati osservati in Sicilia 191 casi in un periodo che va dal 1867 al 1897.

Nel 1898, quando alla direzione della Clinica dermosifilopatica di Palermo gia era stato chiamato il prof. Tommasoli, per iniziativa di questi fu inviato un questionario molto ampio a tutti i medici di Sicilia, allo scopo di stabilire se, dopo un decennio dall' ultima statistica del Ferrari, esistevano ancora leprosi gia conosciuti e nuovi casi si fossero manifestati.

Debbo ripetere, a proposito di tale inchiesta, cio che gia dissi per i leprosi sardi: non è possibile, cioè, che tutti i medici che dovevano rispondere al questionario abbiano avuto la competenza di registrare tutti i leprosi del loro territorio. Pur ammettendo, quindi, che sieno stati segnati tutti i casi piu conclamati, la cui diagnosi, del resto, è fatta non poche volte anche dal volgo, si puo stare sicuri che moltissime forme nervose piu difficilmente riconoscibili, e tutte le forme frustes che richiedono conoscenze non troppo superficiali sulla lepra e sulle malattie nervose, sono andate certamente perdute. Difatti ecco qua che cosa ci dice la statistica compilata dal Dott. Callari[1]): leprosi viventi 43 (nomini 23, donne 20) leprosi morti 27 (nomini 17, donne 10). Dei malati viventi, ben 28 sono affetti da forme tuberose e soltanto 7 da forme maculo anestetiche.

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1) Callari, J., La lepra in Sicilia. Giorn. it. delle mal. vener e della pelle Fas. 3°. 1899.

Se confrontiamo questi risultati con quelli ottenuti da me in Sardegna, il contrasto è evidentissimo. Io ho avuto semplicemente tutto il rovescio: grande prevalenza di leprosi nervosi su quelli tuberosi. Non è strano che realmente esistano tali differenze nelle forme cliniche della lepra in due isole che si trovano presso a poco nelle stesse condizioni climatiche, telluriche, economiche e sociali? Evidentemente la causa sta tutta nella insufficienza delle ricerche. Tanto è cio vero che un altro osservatore, il Calderone[1]) che si è occupato in special modo della lepra nervosa, ne ha ritrovati otto casi a forma maculo anestetica, o mutilante o del tipo della malattia Morvan, tutti malati sfuggiti all' inchiesta del Callari.

Quanti mai altri ve ne saranno in Sicilia di codesti leprosi nervosi? Senza dubbio moltissimi.

Sull' altra questione importante dell' ereditarietà e contagiosità, il Callari opina che in ambedue i modi avvenga la trasmissione della lepra, fondandosi, per ammettere l' ereditarietà, sulla presenza della malattia in membri della stessa famiglia. In una seconda pubblicazione[2]), però, parla meno di ereditarietà; anzi descrive sommariamente la storia di una famiglia in cui la malattia sarebbe passata per contagio dal padre alla figlia e poi ai nipoti, l' una di 8 anni l'altra di 5.

Per spiegare come la lepra sia malattia eminentemente famigliare il Callari ricorre alla predisposizione ereditaria dei figli dei leprosi, e per darsi ragione dei casi che restano immuni, malgrado i contatti ripetuti, pensa alla immunità naturale.

Da parte mia, in base ai dati di fatto desunti dall' esame dei leprosi sardi, non potrei sottoscrivere a codeste interpretazioni. Prima di tutto a me risulta che moltissimi figli di leprosi, specialmente nervosi, (molto meno pericolosi pel contagio dei tuberosi) non ammalano, secondariamente debbo soggiungere che tanto a me come, del resto, ad altri, è successo di osservare moltissimi leprosi di tutte le età, costituzione etc., i quali, senza alcun precedente in famiglia, e quindi senza predisposizione di sorta, hanno contratto la malattia come qualunque figlio di leproso. Andiamo cauti, adunque, prima di accettare ad occhi chiusi tanto la predisposizione ereditaria quanto l' immunità naturale per la lepra, e vediamo se non sia piu semplice ed ovvio l' ammettere che i figli dei leprosi piu sovente di altri si ammalano perchè piu facilmente, si trovano nelle condizioni di contagiarsi, e, d' altra parte, alcuni membri di una stessa famiglia restano incolumi per il fatto che il bacillo, essendo dotato di scarso potere d' attecchimento e d' innesto, richiede contatti intimissimi e prolungati che pure non hanno taluni individui i quali convivono in una stessa famiglia con leprosi.

Nessun caso fu osservato dal Callari in Sicilia prima dei 3 anni d'età.

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1) Calderone, C., Contributo clinico, batteriologico e anatomo patologico allo studio della lepra sistematica nervosa, della siringomielia e della malattia di Morvan. Giorn. it. delle mal. ven. e della pelle. Fas. 6°. 1901.

2) Callari, Contributo alla casistica e patogenesi della lebbra. Gazz. sic. di Med. e Chir. 1903.

Quasi tutti i malati abitano paesi sul mare o vicino al mare.

La durata della malattia sarebbe relativamente breve (media di 5 anni). Notiamo, a questo proposito, che non essendo facile stabilire l'inizio vero della malattia, ci sembra quel termine medio di 5 anni troppo breve per una malattia che decorre tanto lentamente in tutti i paesi nei quali domina endemica.

Nel 1902 [1]) lo stesso Callari pubblicò tre altri casi nuovi, tra cui una donna vivente in una località ritenuta fino allora immune da lepra.

In ultimo debbo ricordare altri 7 casi, non contemplati nella inchiesta Callari, studiati del prof. De Luca nella Clinica dermosifilopatica di Catania ed altri 16 visti dal prof. Melle nella Clinica di Messina.

Italia settentrionale.

Piemonte. — Fino a pochi anni fà si riteneva il Piemonte del tutto immune dalla lepra. Il primo accenno si ha nella relazione del prof. C. Pellizzari, il quale per notizie private avute dal prof. Giovannini, potè dare qualche ragguaglio sopra 6 casi.

Nel 1898 l'Allgeyer [2]) gia porta a 10 i casi osservati e nel 1901 a 15, distribuiti in otto località diverse.

Interessanti sono le stonrie di due fratelli leprosi, ambedùe nati gemelli, l'uno con un fratello l'altro con una sorella, rimasti sanissimi senza alcun sospetto di lepra. Questo fatto certo di due gemelli, di cui uno solo è malato, sta contro all'origine germinativa o placentare della infezione e ci dà una prova di piu del contagio avvenuto dopo la nascita.

Merita pure d'essere ricordato che dei due sunnominati fratelli l'uno ha una forma nodulare tipica e l'altro invece una forma nervosa, tipo malattia del Morvan, presso a poco come accadde di osservare a me in una famiglia sarda, nella quale accanto a due fratelli con lepra nodulare grave, ho visto una sorella con forma nervosa del tipo della sclerodattilia. Questa presenza contemporonea in una stessa famiglia di forme nervose. talvolta leggiere ed atipiche, e nodulari, deve essere tenuta in molta considerazione per spiegare certe oscure forme cliniche nervose, le quali, osservate in paesi dove la lepra persiste ancora, debbono, per i loro caratteri, farci sempre sospettare un nesso etiologico coll'infezione leprosa.

Un altro caso di lepra tubercolare l'ho osservato io in Piemonte [3]) nella persona di una donna con marito e due figlie, l'una di 9, l'altra di 7 anni, tutti immuni da lepra. La donna ora è morta per malattia intercorrente.

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1) Callari, J., Tre nuovi casi di lepra in Sicilia. Rassegua intern. della Med. moderna. 1902. No. 19.

2) Allgeyer, Nuove osservazioni sulla lebbra in Piemonte. Riv. d'ig. e sanità publ. Anno XII. 1901. La lebbra in Piemonte. Gazz. med. di Torino. No. 12. 1898. —

3) Mantegazza, U., A proposito di un caso di lepra tubercolare osservato nella proinicia di Pavia. Riforma med. No. 250—251. 1900.

La gran maggioranza dei leprosi di Piemonte hanno forme tubercolari, cio che ci fa sospettare come molti casi a tipo nervoso debbano essere sfuggiti alle ricerche fatte.

Infine debbo accenare a tre casi studiati nella Clinica dermosifilopatica di Pavia, tutti e tre italiani che contrassero la malattia in America, dove sono stati emigrati per parecchi anni. —

Liguria. È noto che in diversi paesi della Riviera di ponente vi sono sempre attivi focolai di lepra autoctona. Non avendo potuto fare ricerche personali, ricordero soltanto che nella Clinica dermosifilopatica di Genova sono stati curati dal prof. Profeta 9 leprosi liguri fino al 1902.

Lombardia, Veneto.. L'amico dott. Bertarelli, medico primario specialista dell'ospedale maggiore di Milano, gentilmente mi comunica notizie di due leprosi, padre e figlio da lui curati in quell' ospedale.

Il padre, ora morto, contrasse la lepra in America e la trasmise, molto probabilmente per contagio, al figlio che non è mai useito dalla nativa Lombardia, dove, finora per lo meuo, focolai autoctoni di lepra non sono stati descritti. Evidentemente qui abbiamo la prova sicura della possibilità che individui leprosi, contagiati in America e ritornati in patria, disseminino la malattia specialmente in famiglia.

Un altro italiano, che divenne leproso nel Brasile, fu curato recentemente nell'ospedale di Venezia. Il prof. Fiono, che cortesemente mi dà la notizia, mi conferma pure di non avere visto altri leprosi in quell' ospedale all' infuori di due marinai negri colà di passaggio. Poco posso dire del forolaio di lepra, ben noto, di Comacchio. Per informazioni dello stesso Fiocco risulta che fino a poco tempo fà erano viventi 17 leprosi, alcuni dei quali affetti da forme schiettamente nervose.

Emilia. Per squisita cortesia del prof. Mibelli posso riferire sopra due casi di lepra (di cui uno molto importante) curati ambedue nella Clinica dermosifilopatica di Parma.

Il primo riguarda un individuo con lepra mista (ora morto per broncopneumonite) contratta senza dubbio in America, dove il malato piu volte emigrò.

L'altro leproso è nativo di un paese del Parmense in cui si trovano di passaggio o stabili parecchi emigrati italiani che ritornano in patria dall'America per curarsi di malattie o per altre cause. Dal 1874 codesto individuo, quando non aveva affatto alcun accenno di lepra, visse attendendo a lavori manuali per un periodo di 2 anni, a Nizza, Tolone e Cette, dove si sa che vivono tuttora parecchi leprosi. Con questi, però, pare non abbia avuto contatto qualsiasi. Ritirossi, poscia, nel suo paese e vi godette sempre ottima salute. Soltanto nel 1897 conobbe un tale, reduce dall' America quasi certamente leproso, e con lui visse in grande dimestichezza ed intimità.

Nel 1899 s'accorse dei primi sintomi della lepra (febbri intermittenti, dolori reumatoidi e noduli) diagnosticata e curata nella Clinica di Parma.

Escludendo, nel caso speciale, che l'infezione rimonti all' epoca in cui il paziente fu a Nizza, si deve senz' altro ammettere il contagio

avvenuto per i rapporti d' intimità del malato col leproso ritornato d' America.

Il caso è pure istruttivo per quel che riguarda l' incubazione della malattia, che deve essere stata inferiore ai due anni, perchè tra i primi contatti del sano col leproso ed i primi sintomi gia ben chiari della malattia trascorsero appena due anni.

Secondo notizie comunicatemi gentilmente da prof. Mazza, risulta che nella Clinica oculistica di Modena è stata curata dal prof. Albertotti per lepromi congiuntivali primitivi una donna, della quale mi sono ignoti i particolari clinici, il luogo di nascita e di dimora.

Italia centrale.

Toscana. Per ricerche fatte dal prof. C. Pellizzari specialmente quando era Direttore della Clinica di Pisa, si sa che fino a pochi anni fà esisteva un piccolo focolaio leproso di 2—3 casi nell' isola d' Elba e qualche caso isolato anche a Livorno. Recentemente sono stati studiati e curati nella Clinica di Firenze un uomo ed una donna, leprosi provenienti dall'America.

Nessun caso fu visto dal 1897 ad oggi nella Clinica di Siena, come m' informa gentilmente il prof. Barduzzi.

Marche. Nel 1900 è stato scoperto dal dott. Ungaro medico provinciale, (1) un piccolo focolaio nella provincia di Pesaro-Urbino, dove fino allora non si sapeva davvero ch' esistesse la lepra.

Si tratta di due donne, l' una di 26, l'altra di 15 anni, ambedue affette da forme tubercolari, che datano rispettivamente da 4 anni e da pochi mesi.

E difficile stabilire l' origine dell' infezione, se, cioè, sia stata importata da qualche altro focolaio italiano o d' America, oppure se sia da considerarsi come lepra autoctona ancora sconoscinta. Forse sarà piu probabile la prima ipotesi, mancando affatto alcuna notizia anamnestica riguardante leprosi in famiglia o nel paese dove vivono le due malate.

Comunque sia, del resto, è molto probabile che la malattia dalla sorella piu anziana sia passata per contagio a quella piu piccola.

Italia meridionale.

Nel 1897 C. Pellizzari, per informazioni private avute dal prof. De Amicis e dal dott. Jaia, segualava circa 27 casi sparsi nelle provincie di Lecce, Potenza, Aquila, Cosenza, Bari.

Dettagliate notizie posso dare ora per cortesia degli stessi prof. De Amicis e dott. Jaia, i quali si compiaequero comunicarmi tutti i casi osservati rispettivamente nella Clinica dermosifilopatica di Napoli e nell' ospedale di Bari dal 1897 fino ad oggi.

Dei casi antichi, gia notati nella relazione Pellizzari, non si sa quanti ancora siano viventi. Certo è che una grande parte di essi devono essere morti, perchè i dati raccolti sopra 18 leprosi (Jaia) rimontano al 1886.

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1) Ungaro, Due casi di lebbra in provincia di Pesaro-Urbino. Riforma medica. Vol. IV. No. 65. 1900.

Dal 1897, il De Amicis ha studiato nella sua Clinica fen 16 casi, dei quali 14 sono nuovi non ricordati dal Pellizzari, e lo Jaia ha visto altri 4 casi oltre quelli gia computati.

In tutto 18 leprosi.

Il De Amicis, poi, ha potuto raccogliere, per dichiarazioni dei malati, altri 8 casi, congiunti da parentela con quelli osservati.

Cosi che complessivamente si avrebbero in tutto 26 nuovi casi di lepra.

Dallo spoglio dei dati fornitimi spiccano subito diverse località infette, in cui la lepra colpisce maggiormente individui che non sono mai usciti dal paese nativo, località che si devono ritenere quasi certamente come focolai autoctoni, la cui origine risale a tempi assai remoti.

Una di queste regioni leprose è la provincia di Bari (7 casi), un' altra è la provincia di Cosenza (5 casi) una terza è la provincia di Lecce (3 casi).

Leprosi isolati, che non si sa bene se siano casi sporadici o stieno a rappresentare focolai autoctoni, sono sparsi a Reggio Calabria, Miranda (Isernia), Miglionico (Basilicata), Avellino.

Ancora sono da ricordare 4 leprosi ritornati gia malati dall' America, dove vissero in regioni leprose, ed un sardo nativo di Oristano, paese nel quale la lepra è endemica.

Di piu rammenterò un altro caso visto da me nel 1901 in una famiglia di minatori che lavorava al traforo del Sempione.

Infine merita una speciale menzione un caso molto importante, che fu oggetto di una comunicazione del prof. De Amicis (1) alla Società it. di dermatologia.

Si tratta di un individuo di 52 anni, non mai allontanatosi da Napoli, affetto da 6 anni da manifestazioni di lepra tubercolare ed anestetica. Questo leproso, essendo vissuto per molti mesi con un giovinetto, figlio di un suo amico, gli trasmise la malattia. Ed ora il giovanetto ha una lepra conclamata con piccoli tubercoli incipienti, rinite leprosa etc.

Quasi tutti i leprosi meridionali hanno forme tuberose: pochissimi sono quelli nervos.

Questo fatto lascia adito al sospetto che anche nelle provincie meridionali si nascondano molti leprosi nervosi, specialmente con quelle forme frustes che sono tanto comuni in Sardegna.

Ora che ho riassunto in modo sommario tutti i fatti che, nella ristrettezza del tempo a me concesso, mi fu possibile mettere in rilievo sulla diffusione della lepra in Italia, debbo dichiarare subito che illusione sarebbe il credere che tutti i leprosi d' Italia fossero conoscinti. Finchè il Governo italiano non si occuperà seriamente delle ricerche dei leprosi, valendosi dell' opera e del consiglio di tutti coloro che conoscono la

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1) T. De Amicis. Un caso di lepra autoctona osservato nella città di Napoli, contagio consecutivo in un giovinetto.
Giorn. it. della mal. ven. e della pelle. 1902. Fas. V.

malattia ed hanno buona volontà di rintracciarne i casi, avremo sempre a lamentare che in Italia manca una statistica veramente esatta e completa dei leprosi. E questa lacuna è, sotto ogui riguardo, deplorevole, perchè, mal conoscendo dove s'annida il morbo, la profilassi, che in Italia è tutta da farsi benchè i molti casi di contagio ne richiederebbero urgente applicazione, non potrà essere di necessità che insufficiente ed incompleta.

Mi è grato rendere pubblicamente vive grazie per la validissima cooperazione prestatami ai Signori Professori Barduzzi, De Amicis De Luca, Giovannini, Mazza, Melle, Mibelli, Colombini, C. Pellizzari, direttori rispettivamente delle Cliniche di Siena, Napoli, Catania, Torino, Modena, Messina, Parma, Sassari, Firenze, al prof. Truffi, assistente alla Clinica di Pavia, al prof. Fiocco, medico primario dell' ospedale di Venezia, al dott. Bertarelli, medico primario dell' ospedale maggiore di Milano, al dott. Jaia, medico primario dell' ospedale di Bari.

Montenegro.

Bericht

von

B. Perazitsch in Cetinje.

In Beantwortung Ihres Geschätzten vom 8. Juni, bezüglich der Lepra und ihrer Ausbreitung in Montenegro, beehre ich mich Ihnen mitzuteilen, dass wir ungefähr 100 Leprakranke haben, die ausschliesslich in den an der albanesisch-herzegovinischen Grenze anstossenden Gebieten verbreitet sind, dass dieselben, da wir keine Asyle besitzen, auf Grund einer von Seite des Ministeriums des Innern erlassenen Verordnung, in ihren eigenen Wohnstätten streng isoliert sind.

Diesen Kranken ist sowohl von Seite der Regierung als von der Kirche die Eheschliessung verboten.

Bei uns kommt die Lepra in allen drei Formen vor, nämlich als Lepra tuberosa, als Lepra maculo-anaesthetica und als Lepra mixta.

Als eine unstrittige Tatsache kann angesehen werden, dass uns die Lepra aus der Türkei importiert wurde, denn die obenerwähnten Gebiete waren vor dem Berliner Kongresse türkisch.

Was das Geschlecht betrifft, so kann ich auf Grund unserer gesammelten Beobachtungen hervorheben, dass die Lepra bei uns vorwiegend das männliche Geschlecht befallen hat und dass das Auftreten derselben zwischen 18 und 50 Jahren erfolgt.

Was das ätiologische Moment anbelangt, so kann man behaupten, dass hier die Ansteckung die grösste Rolle spielte und zwar durch engen Verkehr, sowie durch Zusammenleben der Leute.

Dies ist alles, was ich in der Lage bin, Ihnen über die Lepra in Montenegro zu berichten.

Norwegen.

Bericht

von

G. Armauer Hansen in Bergen.

Da Dr. Jonathan Hutchinson fortwährend an der alten Lehre von der Entstehung der Lepra durch verdorbene Fischnahrung festhält, und unter anderem behauptet, dass die Lepra in Norwegen nicht infolge der Isolierung der Leprösen zurückgegangen ist, sondern dadurch, dass die Norweger gelernt haben, ihre Fischspeisen besser zu bereiten, als früher, fühle ich mich veranlasst, noch einmal die Geschichte der Lepra in Norwegen im vorigen Jahrhundert etwas näher zu beleuchten.

Wie häufig die Lepra in der ersten Hälfte des vorigen Jahrhunderts war, können wir leider nicht mit Bestimmtheit wissen. Im Jahre 1836 wird die Zahl 659 angegeben und 1845 1122; diese letzte Zahl nach einer Zählung durch die Priester. Bei dieser sind natürlicherweise viele Lepröse übersehen worden. Erst im Jahre 1856 wurden regelmässige jährliche Zählungen durch die Aerzte angeordnet und seit der Zeit können wir unsere Statistik als zuverlässig ansehen. Glücklicherweise hatte ein jetzt verstorbener Beamter an der Pflegeanstalt in Bergen, Herr Hartwig, alle die angemeldeten Leprösen bei Namen nach ihren Heimstätten aufgezeichnet und bei jedem die Krankheitsdauer angeführt. Hierdurch wurde es möglich, jeden neu angemeldeten Leprösen zu dem Jahre zurückzuführen, da seine Krankheit angeblich angefangen hatte. Da die Leprösen fast immer ihre Krankheit so lange wie möglich verheimlichen, haben sie alle, wenn sie entdeckt und angemeldet werden, schon mehrere Jahre Krankheitsdauer und müssen also in der Statistik in einem früheren Jahre aufgeführt werden. Hierdurch wird die Statistik doch noch fehlerhaft, weil die Kranken keine genauen Angaben über ihre Krankheit dann machen können; aber diese Fehler sind wahrscheinlich so ziemlich gleichmässig verteilt, so dass sie auf den Vergleich der verschiedenen Jahre keinen Einfluss haben. Ferner können wir mit Sicherheit annehmen, dass wir durch die seit 1856 angefangenen Zählungen genaue Kenntnis von der Zahl der in den Jahren 1851—55 hinzugekommenen neuen Fälle von Lepra bekommen haben.

Bei diesen Zählungen wissen wir jetzt, dass es Ende 1856 2598 Lepröse in Norwegen gab, und dass in den fünf Jahren 1851—55 1115 neue Fälle hinzukamen, und in den fünf Jahren 1856—60 1163. Hieraus können wir erstens schliessen, dass die Zahl 1122 im Jahre 1845 gewiss zu niedrig ist, und zweitens, dass die Leprafälle im Jahre 1850 ungefähr ebenso zahlreich waren wie 1856 und drittens, dass die Lepra höchst wahrscheinlich in Zunahme in der Mitte des Jahrhunderts war, weil die Zahl der neuen Fälle 1856—60 grösser ist als 1851—55, besonders wenn man annimmt, dass die Zahl der neuen Fälle von der Anzahl der in früheren Jahren lebenden Leprösen abhängig ist, und das glaube ich später begründen zu können. Nachstehende Tabelle zeigt den Gang der Lepra seit 1856—1900.

Tafel über die Zahl der Leprösen innerhalb und ausserhalb der Anstalten in den Jahren 1856—1900.[1]

Jahre	Neue Fälle	Abgang				Gesammelter Abgang	Anzahl der Leprösen im Lande	Abnahme
		durch Tod	in die Anstalten	durch Heilung	durch Auswanderung			
1856 . . .	—	—	—	—	—	—	2598	—
1857—1860 .	1148	668	585	6	31	1290	2218	14,6 %
1861—1865 .	1028	549	732	9	45	1335	1911	13,4 %
1866—1870 .	979	498	573	9	47	1127	1763	7,7 %
1871—1875 .	703	456	434	8	66	964	1502	14,8 %
1876 . . .	117	88	79	1	6	174	1445	—
1877 . . .	111	78	92	1	7	178	1378	—
1878 . . .	106	61	61	6	8	136	1348	—
1879 . . .	85	69	70	3	10	152	1281	—
1880 . . .	77	66	96	2	7	171	1187	20,9 %
1881 . . .	63	75	61	2	8	146	1104	—
1882 . . .	71	52	37	1	7	97	1078	—
1883 . . .	92	53	63	5	5	126	1044	—
1884 . . .	63	76	50	3	2	131	976	—
1885 . . .	77	77	63	8	12	160	893	24,7 %
1886 . . .	57	64	73	9	9	155	795	—
1887 . . .	57	37	49	1	3	90	762	—
1888 . . .	43	43	52	4	1	100	705	—
1889 . . .	48	34	54	7	12	107	646	—
1890 . . .	52	57	50	5	2	114	584	34,6 %
1891 . . .	31	45	45	4	2	96	519	—
1892 . . .	42	36	25	5	2	68	493	—
1893 . . .	34	45	24	6	1	76	451	—
1894 . . .	24	26	16	3	3	48	427	—
1895 . . .	28	26	17	4	2	49	406	30,5 %
1896 . . .	23	16	13	5	5	39	390	—
1897 . . .	25	16	20	6	1	43	372	—
1898 . . .	26	21	21	8	—	50	358	—
1899 . . .	7	22	23	1	1	47	308	—
1900 . . .	7	22	16	—	2	40	275[1]	32,3 %
Zusammen	5224	3376	3494	132	307	7309	—	—

1) Ende 1901 gab es 268; Ende 1902 gab es 243.

Vor 1856 hatten wir an Anstalten, die Lepröse aufnahmen, nur das St. Georgs Hospital, das Lungegaardshospital und ein kleines Reknaes

Hospital in Molde, in welchem im ganzen etwas über 200 Lepröse untergebracht waren. 1857 wurde die erste grosse Pflegeanstalt in Bergen eröffnet, die allein 250 Kranke aufnehmen konnte, und 1861 wurden zwei Anstalten, die eine in Molde und die andere in Trondhjem eröffnet, die zusammen etwa 500 Kranke beherbergen konnten. Wie man aus der Tabelle sieht, werden in den Jahren 1857 bis 1860 schon 585 in die Anstalt bei Bergen eingelegt oder isoliert, und in denselben Jahren nimmt die Zahl der Leprösen im Lande um 280 ab. Diese zwei Umstände, die Isolierung so vieler Lepröser und die Abnahme der Gesamtzahl derselben harmonieren nach meiner Auffassung sehr wohl. Sollte für die Abnahme Hutchinsons Erklärung anwenden, müsste man annehmen, dass die Verbesserung der Fischspeisen mit dem Jahre 1857 plötzlich eingetreten war; denn wie oben angegeben ist, haben wir Grund anzunehmen, dass die Lepra eher in Zunahme vor diesem Jahre war. Nun ändert sich die Lebensweise eines Volkes kaum je ganz plötzlich; die Reformen in dieser Beziehung geschehen eben allmählich. Stellt man einander gegenüber die zwei Möglichkeiten: Eine plötzliche Aenderung in der Zubereitung der Fischspeisen mit folgender Abnahme der Lepra und Isolierung so und so vieler Leprösen und als Folge davon Abnahme, so scheint mir jedenfalls die Wahl nicht schwierig. Ausserdem kann es bestimmt behauptet werden, dass damals gar keine Verbesserung in der Zubereitung der Fischspeisen eingetreten war. Noch in den Jahren 1871 und 72, als ich in mehreren Landdistrikten die Ausbreitung der Lepra untersuchte, fand ich die Lebensweise der Bauern ganz so wie von früheren Untersuchern beschrieben; und damals hatte die Krankheit schon nicht unbedeutend abgenommen. Man kann daher nach meiner Meinung sagen, dass die Lepra in Norwegen abgenommen hat, trotzdem man Fische, und oft schlecht zubereitete Fische genossen hat.

Was die oben berührte Frage von der Abhängigkeit der Zahl der neueren Fälle von der Anzahl der früher lebenden Leprösen anbetrifft, so wird man aus der Tabelle ersehen, dass die Zahl der neuen Fälle stetig abnimmt seit 1860, das heisst, seit die Isolation zu wirken anfing, während dieselbe Zahl in den Jahren 1856—60 höher war als in den Jahren 1851—55. Die Zahl der neueren Fälle in den Jahren 1856—60 war abhängig von der Zahl der Leprösen in den Jahren 1851—55 oder noch früheren Jahren. In den Jahren 1857—60 sind 585 Lepröse isoliert worden und in den Jahren 1861—65 bekommen wir nur 1028 neue Fälle gegen 1163 in den 5 Jahren vorher und später sinkt die Zahl der neuen Fälle stetig. Doch ist hierzu zu bemerken, dass die Zahlen für die fünf Jahre 1891—95 und 1896—1900 zu niedrig sind; es dauert wenigstens 10 Jahre, bevor wir volle Kenntnis von der Zahl der Leprösen in einem bestimmten Jahre erlangen, und stetig findet man neue Kranke, die eine noch längere Krankheitsdauer haben. Die nötigen Korrekturen für weiter zurückliegende Jahre werden aber natürlicherweise nur unbedeutende.

Ein anderer Umstand zeigt auch, dass die Abnahme mit der Isolierung in Zusammenhang steht, der nämlich, dass die Abnahme sehr ungleich in verschiedenen Landstrichen ist, und zwar um so grösser je mehrere isoliert worden sind, was aus dem folgenden zu ersehen ist.

In Sóndtjord stellt sich das Verhältnis so:

	Neue Fälle	Tote	In die Anstalten eingelegt	Geheilte	Ausgewanderte	Anzahl am Ende des Jahres
1856	—	—	—	—	—	431
1856—60	214	83=15,0%	211=38,2%	—	4	306
1861—65	156=28,2%	61=15,4%	144=36,3%	—	7	250
1866—70	136=34,3%	62=14,4%	137=38,1%	—	1	196
1871—75	182=50,6%	50=18,8%	86=32,3%	—	12	130

und in Nordmóre so:

	Neue Fälle	Tote	In die Anstalten eingelegt	Geheilte	Ausgewanderte	Anzahl am Ende des Jahres
1856	—	—	—	—	—	105
1856—61	81	32=19,2%	14= 8,4%	3	—	119
1861—65	88=53,0%	43=21,9%	45=22,9%	2	—	117
1866—70	92=47,0%	40=21,5%	43=23,1%	6	—	120
1871—75	57=30,6%	42=25,0%	40=23,8%	2	1	92.

Die Zahl der Leprösen am Ende des Jahres 1855 kennen wir nicht, und wir müssen daher die Zahl am Ende von 1856 aufführen, die wohl so ungefähr dieselbe wie in 1855 ist.

Diese zwei Distrikte entsprechen einander ziemlich genau, was Lage und Lebensweise betrifft. Sie liegen beide an der Küste und die Bevölkerung treibt zum grossen Teile Fischfang und lebt auch viel von Fisch. Die Reinlichkeit, sowohl die der Personen wie die im Haushalt, steht oder vielmehr stand auf einer sehr niedrigen Stufe; aber die Verbesserung in dieser Beziehung ist erst eingetreten, nachdem die Abnahme der Lepra schon in vollem Gange war. Wie schon oben bemerkt, war in der Lebensweise sowie in Bezug auf Reinlichkeit in den ersten 70er Jahren keine Besserung zu bemerken, und in Nordmöre habe ich auch in späteren Jahren die Reinlichkeitsverhältnisse sehr schlecht gefunden.

Nehmen wir nun aber Rücksicht zu der Isolation in beiden Distrikten, dann muss ich zuerst aufklären, wie die angeführten Prozentangaben ausgerechnet sind. Ich gehe davon aus, dass die Leprösen, die in einem Fünfjahre aufgeführt sind, wenigstens 5 Jahre früher krank geworden sind, was selbstverständlich ganz willkürlich ist. Dass aber die Kranken ihre Krankheitsdauer immer zu kurz angeben, ist ganz sicher, und es ist vielleicht kein zu grosser Fehler, wenn ich das Zugangsprozent in einem Fünfjahre aus der Zahl der im vorigen Fünfjahre zu Hause lebenden Leprösen berechne. Einige oder mehrere der neuen Fälle sind wahrscheinlich früher infiziert worden; man kann wohl aber annehmen, dass dieser Fehler so ziemlich gleichmässig unter die verschiedenen Fünfjahre vertheilt ist, so dass der Vergleich zwischen diesen berechtigt wird. Die Prozente der Toten und der Isolierten sind aber aus der Zahl der in demselben Fünfjahre zu Hause lebenden Leprösen ersichtlich.

Man sieht sogleich aus den Zahlen, dass die Sterbefälle lange nicht die Heimaten evakuiert haben, und man sieht ferner, dass in Sóndfjord, wo das Isolierungsprozent das Sterbeprozent mit übersteigt, die Evakuierung schnell geht, während in Nordmóre, wo die beiden Prozente ungefähr gleich sind, erst nach 3 Fünfjahren eine Abnahme anfängt; in den früheren Fünfjahren hält sich die Zahl ungefähr konstant oder wächst

sogar. Berechnet man die Zahl der zu Hause lebenden Leprösen in den zwei Distrikten, so erhält man folgende Zahlen:

Nordmóre	1856—60	166	Sóndfjord	1856—60	552
	1861—65	196		1861—63	396
	1866—70	186		1866—70	360
	1871—75	168		1871—75	266.

In Nordmóre ist in 1861—65 der Zugang 53 %, Todesfälle und Isolierung zusammen 44,8 %, in 1866—70 dieselben 47 % und 44,7 %, in 1871—75 30,6 % und 48,8 %, und erst in diesem letzten Fünfjahre beginnt die Abnahme.

In Sóndfjord dagegen stehen dieselben Prozente so:

1861—65	28,2 %	und	51,7 %
1866—70	34,3 %	und	52,5 %
1871—75	50,6 %	und	51,1 %.

Man sieht also, dass in Sóndfjord der Abgang, dank der Isolation, in allen drei Fünfjahren grösser ist als der Zugang, während das Entgegengesetzte der Fall in Nordmóre ist in den zwei ersten Fünfjahren, und dass erst im dritten der Abgang grösser wird.

Hieraus kann man wohl mit grossem Recht schliessen, dass die Abnahme in Sóndfjord durch die Isolierung bedingt ist, und dass die Lepra daselbst zugenommen haben würde, wenn keine Isolierung stattgefunden hätte, und dass die Zunahme in Nordmóre durch die unzulängliche Isolation da, wo das Zugangsprozent so hoch war, bedingt ist.

Was den steilen Fall des Zugangsprozentes in Nordmóre in 1871 bis 1875 und die Steigerung desselben in Sóndfjord in demselben Fünfjahre bedingt, weiss ich nicht. Um möglicherweise Licht hier zu schaffen, müssen noch alle übrigen Distrikte untersucht werden. Für die Beantwortung der Frage, ob die Isolierung oder die Besserung in der Ernährung eine Rolle für die Abnahme gespielt hat, ist aber das Mitgeteilte genug. Da ich schon oben angeführt habe, dass bis in den Anfang der 70er Jahre nach meinen eigenen Beobachtungen jedenfalls keine wesentliche Besserung in der Ernährungsweise eingetreten war, kann die Abnahme der Zahl der Leprösen in Sóondfjord nur durch die Isolierung bedingt sein; und kann die Isolierung in einer Abnahme der Zahl der zu Hause lebenden Leprösen und diese Abnahme wieder zu einer Minderung der neuen Fälle führen, so kann dies nur dadurch bedingt sein, dass die zu Hause lebenden Leprösen für die Verbreitung der Krankheit verantwortlich sind, und das können sie nur dadurch werden, dass sie frische Menschen infizieren. Ob dies durch die von Hutchinson „commensal infection" genannte Infektion der Nahrungsmittel oder durch Ansteckung stattfindet, will ich hier nicht diskutieren; ich werde nur durch weitere Zahlen zeigen, wie das Zugangsprozent sich in den zwei besprochenen Distrikten bis zum Jahre 1890 stellt. Ich gehe nicht weiter, weil für die späteren Jahre mehrere Korrekturen zu erwarten sind. Man erhält für Nordmóre:

1856—60	166	zu Hause lebende Lepröse und in	1861—65	88	neue Fälle	= 53,0 %,
1861—65	196	„ „ „ „	1866—70	92	„ „	= 47,0 %,
1866—70	186	„ „ „ „	1871—75	57	„ „	= 30,6 %,
1871—75	168	„ „ „ „	1876—80	46	„ „	= 27,4 %,
1876—80	133	„ „ „ „	1881—85	31	„ „	= 23,3 %,
1781—85	105	„ „ „ „	1886—90	27	„ „	= 25,7 %,

und für Sóndfjord

1856—60	552	zu Hause lebende Lepröse und in	1861—65	156	neue Fälle	= 28,2 %.
1861—65	596	„ „ „ „	1866—70	136	„ „	= 34,3 %,
1866—70	360	„ „ „ „	1871—75	182	„ „	= 50,6 %,
1871—75	266	„ „ „ „	1876 80	62	„ „	= 23,3 %,
1876—80	172	„ „ „ „	1881—85	27	„ „	= 15,8 %,
1881—84	123	„ „ ä „	1886—90	20	„ „	= 16,2 %.

Wie man sieht, nimmt das Zugangsprozent in beiden Distrikten ab, hält sich aber höher in Nordmóre als in Sóndfjord. Dies könnte man vielleicht im Sinne Hutchinsons durch eine stetige Verbesserung der Zubereitung der Fischnahrung erklären wollen. Durch die obenstehenden Darlegungen wird dies jedoch ziemlich unwahrscheinlich. Seit den 70er Jahren ist in Sóndfjord aber eine bedeutende Besserung der Reinlichkeitsverhältnisse eingetreten, weniger in Nordmóre, was ich aus eigener Beobachtung weiss; hierzu kommt, dass ich im Anfang der 70er Jahre meine Anschauungen über die Ansteckungsfähigkeit der Lepra hervorbrachte, die von den meisten Bezirksärzten angenommen wurden und von diesen wie von mir selbst auf meinen Reisen dem Volke gepredigt wurden. Die Bauern, die selbst gesund sind, nahmen diese Lehre gern an; die Leprösen selbst dagegen wollen als Regel, nicht erkennen, dass sie ihren Mitmenschen gefährlich sein können weil dieser Umstand ihrem freien Verkehr mit denselben Einhalt tut. Wenn aber die Gesunden sich in acht nehmen und in ihrem Verkehr mit den Leprösen vorsichtig sind, so ist das die Hauptsache.

Was übrigens die Fischhypothese betrifft, so wäre ja Hutchinson, der den Leprabazillus als den Verursacher der Krankheit annimmt, verpflichtet, das Dasein desselben in weniger gut bereiteten Fischwaren darzutun. Ich habe mich nicht verpflichtet gefühlt, ihn daselbst zu suchen, umsomehr, als es gewiss eine fruchtlose Arbeit sein würde, ihre Identität zu beweisen, weil wir keine Experimente anwenden könnten, da die Krankheit bisher nicht mit Sicherheit auf Tiere übertragbar ist. Uebrigens würde es, wie ich schon bei einer früheren Gelegenheit bemerkt habe, gewiss eine verhältnismässig leichte Sache sein, den Leprabazillus zu züchten, wenn derselbe als Saprophyt aufträte.

Wie man aus der anfangs mitgetheilten Tabelle sieht, nimmt die Lepra in Norwegen stetig ab, und wenn auch mit wechselnder, so doch mit grösserer Schnelligkeit in späteren Jahren als anfangs.

Die Zahl der Leprösen in Norwegen ist jetzt so klein, dass zwei unserer Notirungsanstalten in 1894 als solche aufgehoben sind, nämlich das Lungegaardshospital in Bergen und das Reknaeshospital in Molde; das letztgenannte ist in ein Phthisikersanatorium umgewandelt worden, und das älteste unserer Lepraspitäler, das St. Georgshospital in Bergen, soll verschwinden, wenn die jetzt da lebenden Patienten gestorben sind; das Hospital ist ziemlich reich und seine Gelder hat man schon an-

gefangen zur Bekämpfung der Tuberkulose zu gebrauchen. — Wir haben noch die Pflegeanstalt in Bergen und das Reitgjärdet's Hospital bei Trondhjem, die zusammen etwa 500 Patienten aufnehmen können.

Die Patienten können in unseren Anstalten verschiedene Arbeiten ausführen und was sie dabei verdienen, behalten sie selbst; wenn sie Arbeiten für die Anstalten ausführen, werden sie dafür bezahlt.

Für den Transport der Kranken sind keine besonderen Massregeln getroffen und wir haben davon bisher keine schlimmen Folgen gesehen. Die Lepra ist eine Krankheit, vor der man offenbar keine besondere Furcht zu haben braucht. Es bedarf wahrscheinlich ganz besonderer Umstände, um die Krankheit zu aktivieren, Umstände, die wir leider bisher gar nicht kennen.

Oesterreich-Ungarn.

Oesterreich.

Bericht nach amtlichen Informationen aus dem Sanitätsdepartement des k. k. Ministerium des Inneren.

Von

Riehl in Wien.

In Oesterreich, mit Ausschluss Bosniens und der Herzegowina, ist Lepra nur in einigen Bezirken Dalmatiens endemisch und betrifft eine geringe Anzahl von Einwohnern. Seit der Entdeckung dieser Fälle hat eine weitere Ausbreitung der Krankheit insofern nicht stattgefunden, als die Zahl der heute in Dalmatien existierenden Fälle sich nicht vergrössert hat.

Aus diesem Grunde sah sich die k. k. österreichische Regierung nicht veranlasst, auf dem Wege der Gesetzgebung gegen die Lepra Vorkehrungen zu treffen und begnügte sich, durch Verordnungen für Dalmatien die entsprechenden Massnahmen zur Verhütung weiterer Ausbreitung der Lepra einzuleiten.

Seit einer Reihe von Jahren sind die Amtsärzte Dalmatiens beauftragt, der Lepra die grösste Aufmerksamkeit zuzuwenden. Jeder Leprafall oder auch nur im Verdacht der Lepra stehende Kranke muss vom Amtsarzte genauestens untersucht, die Geschichte des Falles sowie der Befund bei dessen Verwandten und mit ihm in Verkehr stehenden Personen erhoben werden.

Ueber jeden dieser Fälle ist an die Sanitätsbehörde eingehend Bericht zu erstatten. Ausserdem ist die Anordnung getroffen, dass von jedem dieser Fälle entsprechende Objekte (Geschwürssekret, Teile der erkrankten Haut oder Schleimhaut) zur bakteriologischen Untersuchung an die Zentralstelle in Wien einzuliefern sind.

Im Jahre 1901 fanden anlässlich der regelmässigen Militärstellung allgemeine Erhebungen bezüglich der Lepra statt und bereiste Fregattenarzt Dr. Zechmeister im Auftrage des Reichskriegsministeriums (Marinesektion) und des Ministeriums des Innern ganz Dalmatien, um alle Leprösen und Lepraverdächtigen aufzusuchen und einer genauen Untersuchung zu unterziehen und eventuell neue Fälle aufzufinden.

Die Gesamtzahl der damals eruierten Leprafälle betrug sieben.

Von diesen sind seither zwei gestorben. Zwei neue Fälle wurden seit 1901 zur Anzeige gebracht, so dass die Gesamtzahl der Leprösen Ende 1903 sieben betrug.

Die Zahl der seit 1901 als Lepraverdächtig angemeldeten Fälle betrug sieben. Bei fünf dieser Kranken ergab langdauernde Beobachtung und genaue Untersuchung, dass sie nicht an Lepra erkrankt waren.

Die bakteriologische Untersuchung der Prüfungsobjekte wurde im Wiener Universitäts-Institut für pathologische Anatomie ausgeführt. Auch wenn der bakteriologische Befund bezüglich der Leprabazillen ein negativer war, blieben die betreffenden Kranken unter ärztlicher Beobachtung und Kontrolle.

Als Verbreitungsgebiet der Lepra in Dalmatien sind die Bezirke Metkovic, Makarsca, Sinj, die Insel Lissa und die bosnisch-herzegowinische Grenze zu bezeichnen.

Im Jahre 1903 wurde in Metkovic mit dem Bau eines Leprosoriums begonnen, welches zur Aufnahme von zehn Leprakranken (resp. Lepraverdächtigen) angelegt ist. Dieses Lepraasyl ist im Laufe des Jahres 1904 vollendet worden.

Bei der übrigen Bevölkerung Oesterreichs kommt Lepra in endemischer Ausbreitung nicht vor.

Für die Fälle von Lepra bei Zugereisten, wie sie namentlich die grösseren Krankenhäuser Wiens zuweilen beherbergen, gelten die allgemeinen Bestimmungen der Gesetze und Verordnungen bezüglich ansteckender Krankheiten.

Ungarn.

Bericht

von

A. Havas in Budapest.

Ein endemischer Leprafall ist in Ungarn nie beobachtet worden. Ueberhaupt wurden erst in der allerletzten Zeit (1901) Fälle von Lepra hier gesehen und fachwissenschaftlich diagnostiziert, die aber alle ihre Erkrankung aus solchen Ländern holten, wo Lepra endemisch vorzukommen pflegt.

Es sind dies 7 Fälle und zwar:

1. Die Familie Wildner. Es sind das fünf Kinder einer nach Brasilien verheirateten Ungarin. Die Familie wohnte in der Stadt St. Paulo, in der Nähe eines Lepra-Asyles, das die Kinder häufig besuchten. Nach dem Tode ihres Gatten kam die Frau mit ihren fünf in Brasilien geborenen Kindern 1901 nach Ungarn zurück. Einige Tage nach ihrem hierortigen Aufenthalt stellte die Mutter ihre Kinder im Spitale der Barmherzigen Brüder dem Primarius Dr. Basch vor, der bei denselben die bakteriologisch erhärtete Diagnose Lepra maculo-tuberosa mutilans stellte.
2. Gy. M., 55jähriger Mann, Ungar, der vor 17 Jahren nach Argentinien auswanderte und von dort nach Paraguay übersiedelte. 1901 erschien Patient auf der dermatologischen Abteilung der Poliklinik und gab an, seit $2^1/_2$ Jahren krank zu sein. Es wurde von Dr. Roth die auch bakteriologisch bestätigte Diagnose Lepra tuberosa diagnostiziert.
3. K. L., 53 Jahre alt, Agent aus Ungarn, der Mittel-Europa nie verlassen hat, hat sich aber geschäftlich längere Zeit in Rumänien und Serbien aufgehalten, also in Ländern, wo Lepra endemisch vorkommt. Patient gibt an, von 1880—1888 öfter in Rumänien und Serbien, einmal während $1^1/_2$ Jahren ununterbrochen, gewesen zu sein, seit 11 Jahren wohnt er ständig in Budapest. Ist seit 8 Jahren verheiratet, kinderlos. In seiner Familie ist nie eine derartige Erkrankung vorgekommen. 1901 erscheint Patient bei Dr. Beck und gibt an, seit 4—5 Jahren an der gegenwärtigen Erkrankung zu leiden. Es wird bei ihm die mikroskopisch erhärtete Diagnose Lepra tuberosa et anaesthetica gestellt.

Es kamen also zusammen 7 Fälle von Lepra tuberosa und an-

aesthetica vor, die alle ihre Erkrankung aus solchen Ländern holten, wo sie sich längere Zeit aufhielten und wo Lepra endemisch vorkommt.

Wie bereits erwähnt, sind alle Fälle maculo-tuberöser Form.

Alle sind männlichen Geschlechtes, im Alter von 5, 9, 11, 13, 15, 53 und 55 Jahren.

Die im Werke über Lepra des Bukarester Professors Dr. v. Babes erwähnte Tatsache, dass unter den von ihm in Rumänien beobachteten Leprafällen auch zwei Ungarn zu finden waren, ferner durch seine Vermutung, dass unter den an der rumänisch-ungarischen Grenze wohnenden stammverwandten ungarischen Rumänen auch Leprafälle vorkommen müssen, veranlasste die königlich ungarische Landessanitätsbehörde, den Sanitäts-Inspektor Dr. Hajos zum Studium der Leprafrage in das ungarisch-rumänische Grenzgebiet zu entsenden. Sanitäts-Inspektor Hajos ging dieser seiner Aufgabe auts gewissenhafteste nach. Er ging von Dorf zu Dorf, von Haus zu Haus und fand trotz dieser skrupulösesten Nachforschung keinen einzigen Fall von Lepra. Ein kleiner Teil des zu erforschenden Grenzgebietes blieb noch zurück, dieser Teil soll heuer durchsucht werden. Der Sanitäts-Inspektor ging noch weiter, er suchte die zwei von Babes erwähnten, aus Ungarn stammenden, in Rumänien wohnhaften Leprakranke auf und konnte konstatieren, dass diese Kranke schon seit langen Jahren in Rumänien wohnhaft sind, dass keiner von ihren Angehörigen je an einer solchen Erkrankung gelitten. Hajos suchte dann im Zuständigkeitsgebiete dieser beiden Leprösen nach und konnte weder bei deren Anverwandten noch anderswo Lepra finden. Es kann also mit voller Berechtigung angenommen werden, dass die von Babes erwähnten zwei Fälle von Lepra bei Ungarn, von denselben in Rumänien akquiriert wurden.

Da aber bei dem regen Kontakte der Bevölkerung im ungarisch-rumänischen Grenzgebiete nicht ausgeschlossen ist, dass Lepröse von Rumänien zum temporären oder längeren Aufenthalt nach Ungarn kommen, wurde die allgemeine Anmeldungspflicht für Lepra in Aussicht genommen, und wird das Grenzgebiet streng bewacht.

Die in Budapest vorgekommenen Fälle wurden alle der Sanitätsbehörde angemeldet, und sind die 5 Kinder der Familie Wildner im Landes-Spitale in Pozsony auf der infektiösen Abteilung interniert und strengstens isoliert. Ein Fall ist nach Triest übersiedelt. Der in Budapest wohnhafte verheiratete Agent steht unter ständiger ärztlicher Ueberwachung, ist verpflichtet, monatlich einmal seine Wohnung zu desinfiziren, ist verpflichtet, sowohl Wohnungswechsel als auch bei seiner eventuellen Abreise seinen Aufenthaltsort der Behörde mitzuteilen. Seine Frau wurde über die Natur der Erkrankung ihres Mannes aufgeklärt, und wird ausserdem in gewissen Zeitabständen ärztlich kontrolliert. Ein Isolieren des Erkrankten konnte leider nicht durchgeführt werden.

Da wir also nur eingewanderte Fälle, und diese auch nur in verschwindend kleiner Zahl in der allerletzten Zeit haben, so gibt es keine Asyle, und war auch bisher keine spezielle Notwendigkeit zu besonderen Massnahmen vorhanden, doch wird für die Zukunft behördlicherseits vorgesorgt werden. Die angemeldeten Fälle werden stets in Evidenz gehalten.

Rumänien.

Bericht

Von

V. Babes in Bukarest.

(Hierzu eine Tafel.)

Literatur.

Bei Gelegenheit der ersten Leprakonferenz in Berlin haben weil. Prof. N. Kalendero, Prof. Petrini Paul, Prof. Petrini-Galatz sowie wir selbst über die Lepra in Rumänien referiert.

Ausserdem habe ich in einer grösseren Monographie über „Lepra" in Nothnagels spez. Pathologie u. Therapie, 1901, Verlag Hölder, Wien das reichhaltige Lepramaterial Rumäniens sowie unser gesamtes heutiges Wissen über Lepra, namentlich auf Grund eigener, grösstenteils in Rumänien gesammelter Erfahrungen, zusammengestellt.

Seit der Leprakonferenz wurden in Rumänien ausserdem noch folgende Arbeiten über Lepra veröffentlicht:

1. V. Babes, Sedial bacililor leprei die punct de nedere al invas. al elimin. si al combat. leprei. Rom. Medic. V. 1897 u. Acad. Rom. 1897.

2. V. Babes, Preparationi si culturi din un caz de Lepra. Bul. Soc. de Med., Bukarest 1887. p. 47.

3. V. Babes et Levaditi, Histol. pathol. de l'oeil dans la lèpre. Arch. des Sciences méd. Paris, 5 et 6, 1898.

4. V. Babes et Sion-Moschuna, Observ. sur la lèpre pulmonaire. Arch. de Médec. 1898.

5. V. Babes, Ueber die Kultur der bei Lepra gefundenen Diphtheriebazillen. Centralbl. f. Bakteriologie. 1899. No. 4.

6. V. Babes, Prezenta baciloloi Leprei in cel. nérvósà. Spitalul 1900. p. 193.

7. V. Babes, Lesioni viscerale ale leprei. Societ. anatomica nei 1900.

8. V. Babes, Untersuchungen über den Leprabazillus und über die Histologie der Lepra. Berlin, S. Krager. 1898.

9. V. Babes, Rapport sur la Lèpre. Premier Congrès Egyptien de Médecine. 1902.

10. Bolintineanu, Consideratiuni generale asupra etiolog. si patogeniei leprei in Romania. Inaug.-Dissert. 1899. Bukarest.

11. E. Felix, Lepra nasului a faringelui si a laringelui. Bukarest 1899.

12. M. Goldstein, Organele viscerale in lepra. Societateo anatomica. Bukarest. Mai 1900.

13. N. Kalendero, Lepra anestezica in raport cu asa zisele lepre degenerate. Romania Medicole. V. 1897.

14. N. Kalendero, Lepra anestezica. Bukarest 1898.

15. N. Kalendero, Studii asupra leprei in Romania. Romania Medicala. 1898.

16. Moscuna-Sion, Contributiunie la studiul leprei. Inaug.-Dissert. 1897. Bukarest.

17. S. Nicolau, Turburarile sensibilitatei in lepra. Inaug.-Dissert. 1897.

18. Petrini Galatz, Tratamentul leprei in special-tratamentul ei prin serul Carasquilla. Spitalul 1898.

19. Petrini Galatz, Quelques mots sur le traitement de la lèpre en général et spécialement sur son traitement par les sérums de Carasquilla. 1898.

20. Petrini Galatz, Un cas de lepra. Presa medicala Romana. 1903.

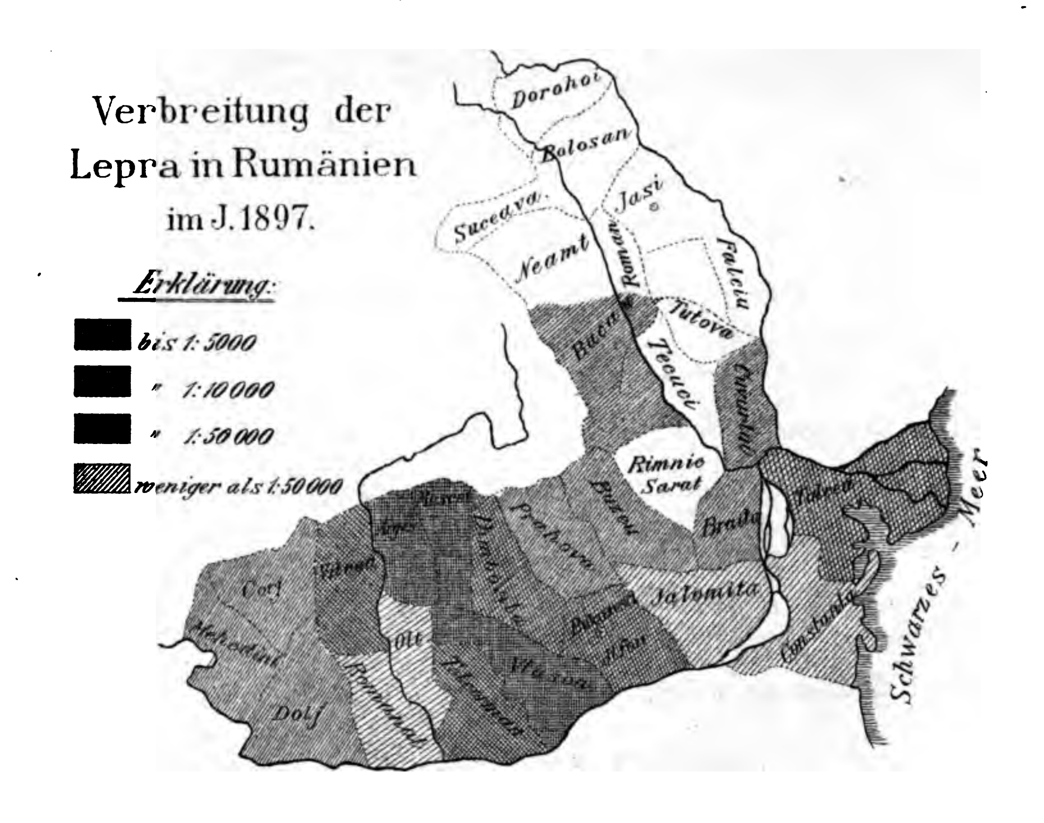
I. Verbreitung der Lepra.

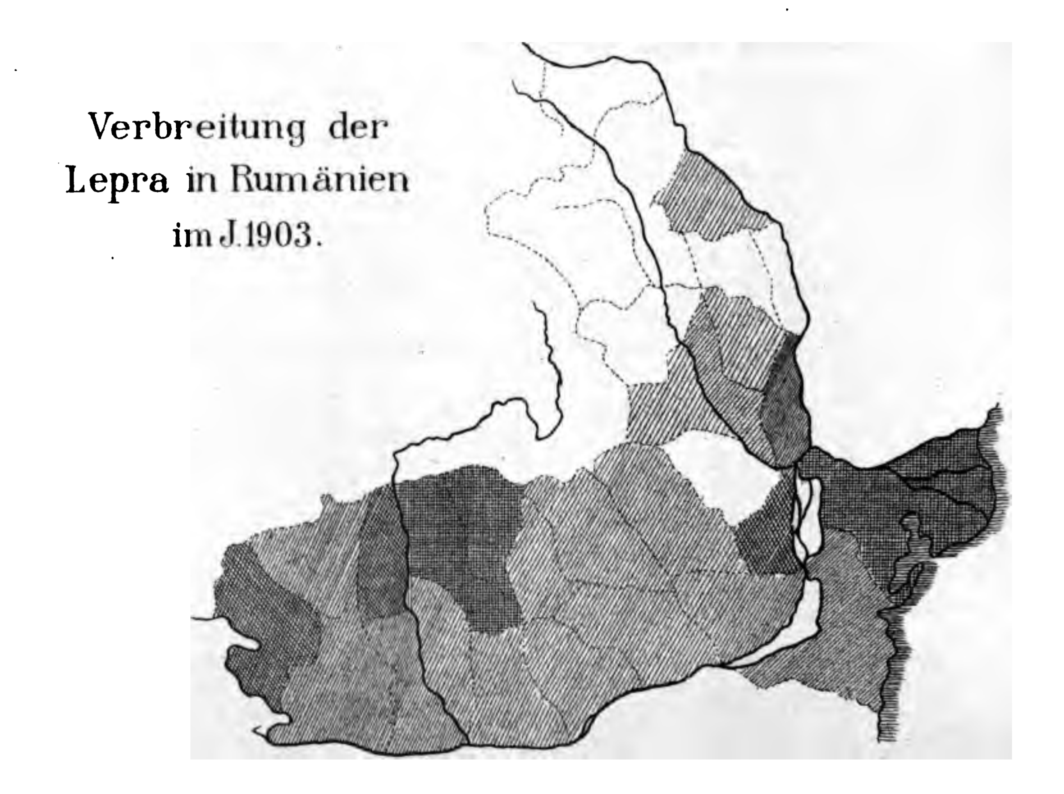
Im Jahre der Lepra-Konferenz waren 208 Leprafälle in Rumänien bekannt, und wurde das namentliche Verzeichnis von 169 Leprösen, welche aber zum Teil schon verstorben waren, in den Veröffentlichungen der Leprakonferenz wiedergegeben.

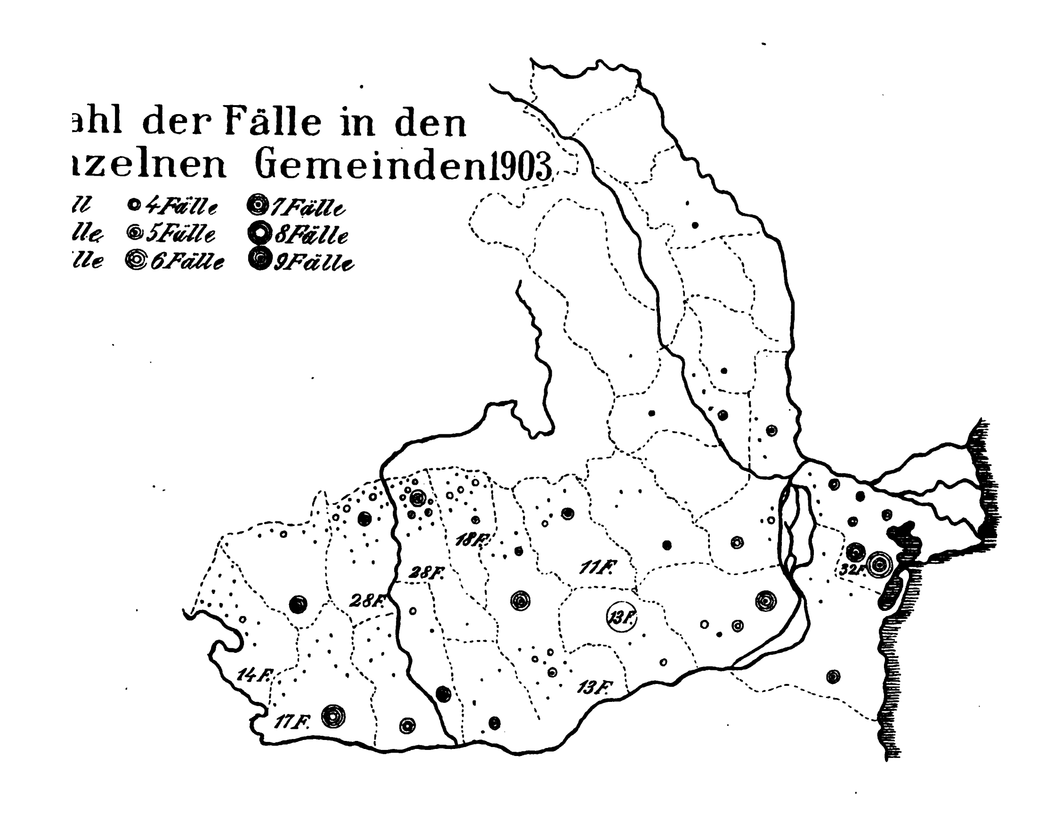
Im ganzen sind seit 1897 folgende Lepröse gestorben:

zu	Arges	16	Personen,
„	Braila	1	„
„	Buzeu	5	„
„	Constantia	4	„
„	Dambovita	1	„
„	Doljiu	9	„
„	Gorzin	6	„
„	Jalomità	4	„
„	Ilfov	1	„
„	Mehedinti	5	„
„	Muscel	6	„
„	Olt	2	„
„	Prahova	1	„
„	Tecucù	2	„
„	Telvormar	5	„
„	Tulcea	22	„
„	Valcea	20	„
„	Vlasca	6	„
	Summa:	116	Personen.

Nicht weiter verfolgt werden konnten im ganzen 5 Lepröse.


Verbreitung der
Lepra in Rumänien
im J. 1897.
Erklärung:
bis 1:5000
" 1:10000
" 1:50000
weniger als 1:50000
Dorohoi
Botosan
Suceava
Jasi
Neamt
Roman
Falciu
Bacau
Tutova
Tecuci
Covurlui
Rimnic Sarat
Buzeu
Braila
Prahova
Jalomita
Olt
Dolj
Corj
Mehedinti
Vlasca
Constanta
Schwarzes Meer

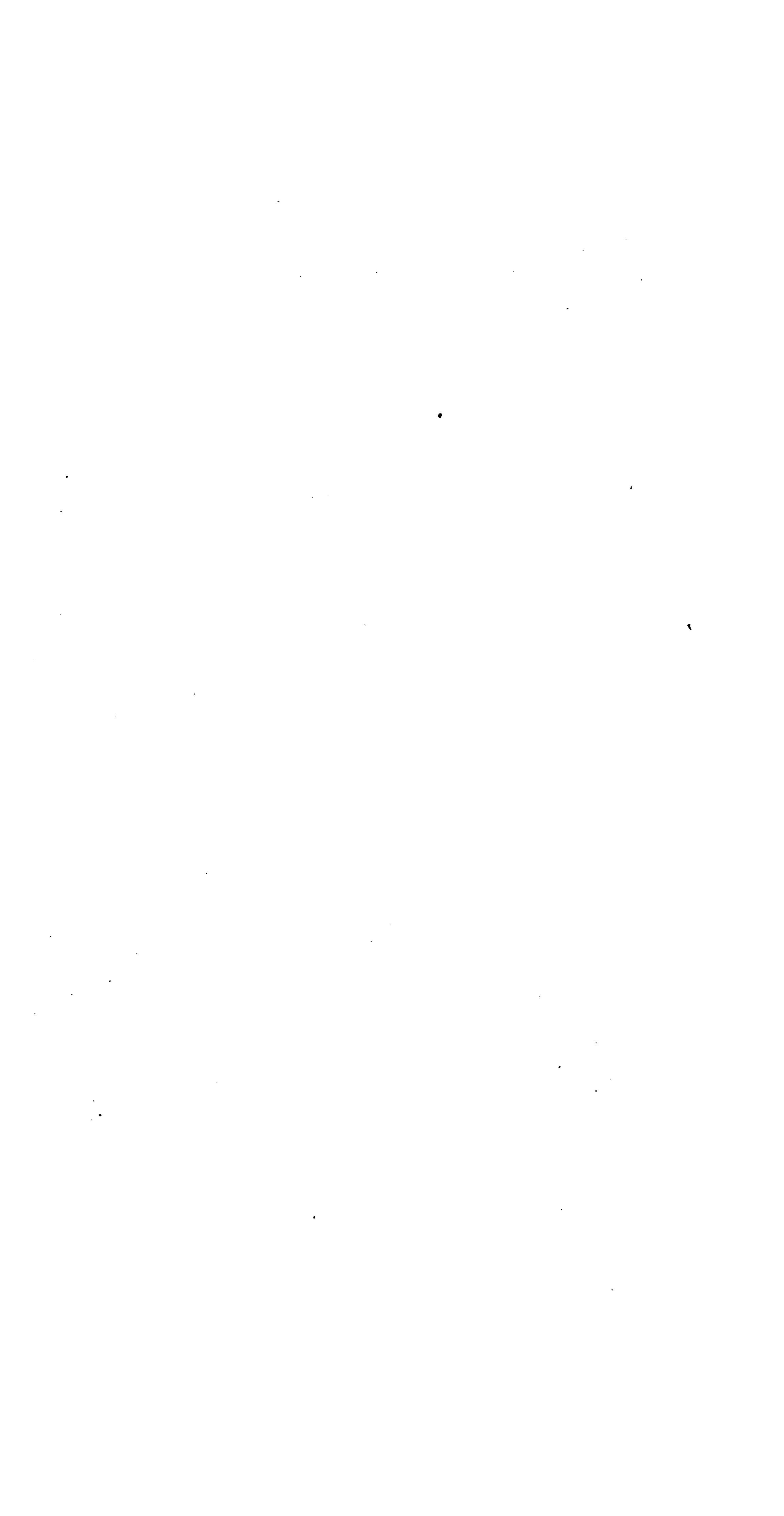

Verbreitung der
Lepra in Rumänien
im J. 1903.



ɔra im Distrikt
Tulcea

19 auf 1000 Einwohner
10 „ „ „
6 „ „ „
3 „ „ „
1 „ „ „

Donau
Carealiu
Tulcea
Letea
Sulina
Donau Delta
S. Georg
Razim
Babadag
Slava Rusa
Schwarzes Meer



Gegenwärtig leben in Rumänien 276 mit Namen bekannte Lepröse. Obwohl namentlich seit 1897 die Aufmerksamkeit aller Aerzte und Sanitätsbeamten in Rumänien auf die Charaktere der Lepra besonders gelenkt wurde, und selbst das Gesetz und das Sanitäts-Reglement es zur Pflicht der Beamten und Aerzte macht, die Leprafälle anzuzeigen und dieselben möglichst zu isolieren, ist es doch bei der Schwierigkeit, gewisse Fälle zu diagnostizieren, wahrscheinlich, dass es noch eine gewisse Anzahl nicht erkannte Leprafälle in Rumänien gibt, besonders in schwer zugänglichen Gegenden, welche eben die Lepraherde in Rumänien bilden, also in den sumpfigen Niederungen des Distrikts Tulcea sowie in den Bergdörfern der Distrikte Arges, Muscel und Valcea.

Gesetzliche Verfügungen.

Das Sanitätsgesetz in Rumänien von 1898 enthält folgende Bestimmungen über Lepra zu Art. 163: „Die Distriktspräfekten sowie die Bürgermeister werden gegen die Verbreitung der chronischen Infektionskrankheiten, besonders der Lepra, der granulösen Augenentzündung, der Syphilis, Tuberkulose, präventive Massregeln ergreifen, und sind ermächtigt, von dieser Krankheit Befallene, insofern dieselben imstande sind, Gesunde anzustecken, in spezielle Spitäler oder Sanatorien einzusenden. Der Staat, die Ephorien, die Distriktshauptstädte haben derartige Spitäler und Sanatorien zu errichten. Nach Art. 164 gehört die Lepra zu den Krankheiten mit obligatorischer Meldungspflicht.

Das Sanitäts-Reglement präzisiert noch, in welchen Fällen Kranke zu Hause isoliert werden können. Der beamtete Arzt überzeugt sich, dass der Kranke in eigener Kammer untergebracht werden kann und untersucht selbst, sowie durch seine Organe, ob die Isolierung genügend durchgeführt werden kann. Während diese Massregeln dazu beigetragen haben, die Leprafälle zu entdecken, war es doch sehr schwer, und nur in einzelnen Fällen durchführbar, die Kranken zu Hause zu isolieren oder in das primitive, von den Lepraherden weit entfernte Lepra-Asyl zu Rachitoasa unterzubringen; wir werden auf dieses Asyl noch zurückkommen.

Vermehrung der Leprafälle.

Meiner Meinung nach sind die Leprafälle seit 1897 nicht seltener geworden, im Gegenteil weist die Statistik eine Vermehrung derselben auf, und zwar hängt dieselbe nicht von unserer Unkenntnis der Fälle ab, welche schon früher bestanden und neuerdings entdeckt worden wären. Nach dem sorgfältig geführten beigefügten Protokoll geht hervor, dass die neuen Leprafälle in der Tat erst in den letzten Jahren begonnen hatten. Wir sehen namentlich, dass die Liste Kalenderos, welche nur auf die im Braukovan-Spital 1870—97 behandelten Fälle sich beschränkt, **169** Fälle aufweist. Kalendero hatte aber in diesem Zeitraum fast alle im Lande bekannten Leprafälle in seinem Spital aufgenommen, sodass diese Zahl einen grossen Teil der damals während 28 Jahren bekannten Leprafälle umfasst. Vom Jahre 1897 bis Ende

1903, also in 6 Jahren, waren nun im ganzen 400 Leprafälle bekannt, von welchen allerdings 116 verstarben und verloren gingen.

Wir müssen ausserdem noch anerkennen, dass mit dem Tode Kalendero's das Interesse an der Lepra und an der Aufsuchung derselben einigermassen zurückging, so dass auch aus diesem Grunde angenommen werden darf, dass die Zahl der Leprösen gegenwärtig grösser ist als im Jahre 1897.

Endlich müssen wir noch bemerken, dass nachträgliche Untersuchungen gezeigt haben, dass auch von den 208 von Kalendero und Petrini Paul gesammelten Fällen mehrere im Jahre 1897 schon gestorben waren oder selbst zweimal gerechnet wurden. Im ganzen können wir demnach behaupten, dass seit 1897 der Kampf gegen die Lepra nicht mit genügender Energie geführt wurde, dass die gesetzlichen und reglementären Bestimmungen in betreff der Isolierung Lepröser durchaus nicht streng durchgeführt wurden, was am deutlichsten aus der Statistik des Rachitasa-Asyls zu ersehen ist. Im Jahre 1897 wurden ins Asyl 20 Kranke aufgenommen, im Jahre 1898 30 Leprakranke, i. J. 1899 10 Leprakranke, i. J. 1900 6 Leprakranke, i. J. 1901 6 Kranke und 1902 7 Kranke. Im ganzen befanden sich zu Ende 1902 25 Leprakranke im Asyl. Im Jahre 1903 wurden mehr Kranke aufgenommen, im ganzen 12 Kranke, und waren 32 Leprakranke bis zu Ende 1903 aufgenommen worden. Doch wurden zu gleicher Zeit 18 Leprakranke in diesem Jahre entlassen! Hieraus ist ersichtlich, dass dieses Asyl seinen Zweck durchaus nicht erfüllt, indem weniger als der 10. Teil der Leprösen in demselben untergebracht sind und die Leprösen von dort bald und in grosser Anzahl wieder nach Hause geschickt werden. Diese verschiedenen hier erwähnten Umstände erklären es zur Genüge, warum die Lepra in Rumänien nicht abgenommen, sondern wesentlich zugenommen hat.

Ausbreitung der Lepra.

Wir wollen nun über die Ausbreitung der Lepra in den letzten Jahren berichten. Die 276 gegenwärtig in Rumänien lebenden Leprösen sind in folgender Weise auf die verschiedenen Distrikte verteilt:

Im Distrikt	Arges	27	Fälle	
„ „	Braila	7	„	
„ „	Buzen	7	„	
„ „	Constanta	4	„	
„ „	Covurlui	3	„	
„ „	Dambovita	9	„	
„ „	Doljiu	17	„	
„ „	Gorjiu	7	„	
„ „	Jalomita	5	„	
„ „	Jasi	1	„	
„ „	Ilfov (mit Bukarest)	29	„	(Bukarest 11 Fälle)
„ „	Mehedinti	25	„	
„ „	Murcel	28	„	
„ „	Olt	7	„	
„ „	Prahova	19	„	

Im Distrikt	Putna	1	Fälle
„ „	Romanati	7	„
„ „	Tecuci	1	„
„ „	Tutova	1	„
„ „	Teleorman	4	„
„ „	Tulcea	36	„
„ „	Valcea	26	„
„ „	Vlasca	4	„

In grösseren Städten sind 23 Leprafälle, während die übrigen in Dörfern zerstreut sind.

Die Krankheit ist in 23 (von 32) Distrikten verbreitet, namentlich in allen Distrikten der Walachei und der Dobrudja mit Ausnahme von Rimnicsarat an der Grenze der Moldau. Die ganze Moldau hingegen ist als leprafrei zu betrachten mit Ausnahme des Distrikts Covurlui zwischen Donau und Prut mit dem grossen Hafen Galatz. In mehreren Distrikten der Moldau findet sich bloss je ein (wohl eingewanderter) Fall. Nur im Distrikt Tecuci, in welchem das Lepraasyl gelegen ist, konnten 3 Fälle nachgewiesen werden, von welchen aber allerdings nicht nachzuweisen ist, dass sie mit dem Asyl in Verbindung waren. Einer dieser Fälle war schon vor der Errichtung des Asyls erkrankt. Jedenfalls lassen es diese Fälle als dringend wünschenswert erscheinen, dass das Asyl nach einer Gegend verlegt werde, in welcher Lepra schon vorhanden ist.

Wenn wir die Verbreitung der Lepra i. J. 1897 mit jener vom Jahre 1903 vergleichen, so finden wir nur geringe Unterschiede. Die am meisten infizierten Distrikte sind Tulcea und namentlich die Fischerdörfer an der Donaumündung und an den grossen Seen, ferner die drei gebirgigen Distrikte Muscel, Arges und Vilcea. Besonders ein Distrikt, Vlasca, in welchem viele Leprafälle vorhanden waren, ist jetzt fast leprafrei, indem die Leprösen grösstenteils verstorben und bloss zwei neue Fälle aufgetreten sind.

Im Distrikt Mehedintzi, an der Grenze zwischen Oesterreich und Serbien, dann im Distrikt Olt in der Nähe von Arges, ferner im Distrikt Braila mit dem grossen Donauhafen Braila haben sich die Fälle vermehrt. Unter den Distrikten, in welchen jetzt weniger Lepra vorhanden ist als früher, müssen wir Ilfov und Dimbovitza erwähnen. In Bukarest selbst finden sich jetzt 13 Fälle, meistens zugereiste, dann auch Fremde, die in Bukarester Spitälern aufgenommen wurden. Wir haben die übrigen Leprösen der Spitäler nicht zu Bukarest, sondern zu den betreffenden Distrikten gezählt. Im Jahre 1897 waren 14 Leprakranke in Bukarest. Die Anzahl der Leprösen in der Hauptstadt ist demnach beiläufig dieselbe geblieben.

Lepraherde.

Wenn wir nun in die Einzelheiten der Verbreitung der Lepra im Lande eingehen, müssen wir uns vor allem den Zweck eines näheren Studiums klar machen. Wir wollen hauptsächlich untersuchen, ob uns die Verbreitungsweise der Lepra nicht irgend welche Aufschlüsse über die Invasion, über die Bedingungen des Entstehens, und über-

haupt über die Kontagiosität der Krankheit zu geben vermag. Was zunächst die Lepraherde an den Donaumündungen und in der Umgebung der grossen Donauhäfen betrifft, so sind dieselben leicht erklärlich. Die Dobrodja, welche erst im Jahre 1878 Rumänien einverleibt wurde, war früher türkisches Gebiet, wo die sehr ausgiebige Fischerei Anlass zum Zusammenkommen und Zusammenwohnen verschiedener Völkerschaften gegeben hatte. In der Tat finden wir hier in der Umgebung der grossen Salzseen Eserul, Razin die grössten Lepraherde, namentlich Jurilanka mit 9 Fällen, Slava-Ruso mit 6 Fällen. In diesem Distrikt sind unter 36 Fällen nur 7 oder 8 Fälle in verschiedenen Lokalitäten zerstreut, von den übrigen Fällen finden sich immer mehrere zusammen in einer Ortschaft, so wie überhaupt in jenen Distrikten, wo viele Fälle vorkommen, dieselben in Gruppen in einzelnen Ortschaften zusammen vorkommen. Schwieriger sind die Lepraherde im Gebirge zu erklären, man war geneigt, dieselben auf eine Invasion bei Gelegenheit des russisch-türkischen Krieges, als die Kosaken monatelang in rumänischen Dörfern lagerten, zurückzuführen. Jedenfalls waren früher bloss ganz vereinzelte Fälle bekannt. Dennoch teile ich nicht diese Ansicht und zwar aus folgenden Gründen:

I. Könnte der Befund bloss vereinzelter Fälle in früheren Zeiten auf mangelhafte Kenntnis der Krankheit zurückgeführt werden.

II. Waren die Russen sowohl in der Moldau als in der Walachei, und auch die Mannschaften, welche mit den Russen in Kontakt kamen, waren aus beiden Teilen Rumäniens. Dennoch aber existiert die Lepra fast nur in der Walachei und nicht in der Moldau.

III. Gerade die Lepraherde in der Walachei befinden sich in Gegenden, in welche die Russen überhaupt nicht gekommen waren.

Man könnte allenfalls annehmen, dass sich in einigen Ortschaften, etwa längs der Donau, infolge des Kontaktes mit russischen Leprösen einige kleinere Lepraherde gebildet haben.

Die Entstehung der Lepraherde in den Karpaten ist demnach ganz dunkel, und können wir höchstens annehmen, dass in früheren Zeiten hier irgend welche Kolonisten aus dem Orient sich niedergelassen haben, welche aber keine Spuren hinterlassen haben. Unbedingt muss angenommen werden, dass hier örtliche Verhältnisse die Ausbreitung und Erhaltung der Krankheit begünstigt haben.

Es ist wünschenswert, dass die grösseren Lepraherde in diesen Gegenden, so Maseciu in Doljin mit 7 Fällen und Govora in Valcea mit 6 Fällen, einer sorgfältigen Enquête unterworfen würden, um die örtlichen Verhältnisse in ihrem Verhältnis zur Lepra genauer zu studieren.

Das Vorkommen mehrerer Fälle in Govora ist dadurch zu erklären, dass dies ein besuchtes Schwefel- und Jodbad ist, in welchem wohl auch Lepröse Heilung suchen.

Ebenso Calimanesti, in welchem ebenfalls einige Leprafälle vorkommen.

Die wenigen Fälle in Sinaia sind wohl so zu erklären, dass in dieser sehr besuchten Sommerfrische zahlreiche Personen aus allen Teilen des Landes zusammenströmen.

Ebenso erklären sich die vereinzelten Leprafälle in den wichtigsten Grenzstationen gegen Ungarn, Predeal und Vercerova.

Hingegen konnten in Ungarn und Siebenbürgen selbst, trotz sorgfältiger Enquête von Seiten der ungarischen Regierung, bloss 2—3 Leprafälle entdeckt werden.

Im Ganzen sind in 108 Fällen mehr Fälle in einer Gemeinde und in 128 Fällen nur ein Fall in einer Gemeinde gefunden worden, was jedenfalls eine Neigung der Lepra, sich in einzelnen Gemeinden zu vermehren, beweist.

Aus den neueren Enquêten geht hervor, dass in vielen Fällen die Lepra sich in einer Ortschaft ausbreitete, nachdem ein fremder Lepröser sich dort niedergelassen hat; allerdings kommt es vor, dass ein Fremder, welcher sich in einer indemnen, nicht leprösen Ortschaft niedergelassen hat, erst später an Lepra erkrankt.

Krankheitsdauer.

Die Krankheitsdauer ist nach den seit 1897 verstorbenen Fällen die folgende:

In	3	Fällen	dauerte	die	Krankheit	1	Jahr
„	3	„	„	„	„	2	Jahre
„	9	„	„	„	„	3	„
„	6	„	„	„	„	4	„
„	13	„	„	„	„	5	„
„	7	„	„	„	„	6	„
„	5	„	„	„	„	7	„
„	11	„	„	„	„	8	„
„	3	„	„	„	„	9	„
„	8	„	„	„	„	10	„
„	5	„	„	„	„	11	„
„	6	„	„	„	„	12	„
„	5	„	„	„	„	13	„
„	4	„	„	„	„	14	„
„	4	„	„	„	„	15	„
„	4	„	„	„	„	16	„
„	3	„	„	„	„	17	„
„	3	„	„	„	„	18	„
„	1	Falle	„	„	„	19	„
„	3	Fällen	„	„	„	20	„
„	1	Falle	„	„	„	21	„
„	1	„	„	„	„	23	„
„	1	„	„	„	„	25	„
„	2	Fällen	„	„	„	27	„
„	1	Falle	„	„	„	69	„

Hieraus folgt, dass unter 113 an Lepra Verstorbenen die Krankheit bloss in drei Fällen im ersten Jahre zum Tode geführt hat. Die akuten Fälle sind demnach bei uns sehr selten. Die meisten Todesfälle kommen zwischen dem 3. und 16. Jahre der Krankheit vor. Im Ganzen 90, also über 80 pCt., aber auch Fälle von über 16 bis zu 27 Jahren sind nicht selten (15 Fälle, etwa 13 pCt.). Ein Lepröser

lebte mit seiner Krankheit selbst 69 Jahre. Die mittlere Lebensdauer eines Leprakranken ist nach diesen Daten demnach in Rumänien etwa 10 Jahre.

Von den heute lebenden Kranken sind seit einem Jahre oder weniger erkrankt 10 Personen. Darunter ein Kind von 8 Monaten, welches seit einigen Monaten die anästhetische Form aufweist. Drei derselben sind an Lepra maculosa, andere an Lepra tuberosa und zwei an Lepra anaesthetica erkrankt. Bei den übrigen ist die Form nicht angegeben. Seit 2 Jahren erkrankt sind 10 Personen, worunter 4 zwischen 10 und 20 Jahren alt.

Seit 3 Jahren erkrankt sind 21 Personen, darunter 7 zwischen 10 und 20 Jahren, ausserdem ein Greis von 82 Jahren.

Seit 4 Jahren erkrankt sind 13 Personen, unter welchen 5 zwischen 10 und 20 Jahren und 2 4- und 7 jährige.

Seit 5 Jahren 22 Personen, unter welchen 5 zwischen 10 und 20 Jahren krank.

Seit 6 Jahren sind 19 Personen, unter welchen 4 zwischen 9 und 20 Jahren.

Im ganzen sind seit der Leprakonferenz (im Jahre 1897) 88 Personen erkrankt, welche gegenwärtig leben. Hierzu können wir etwa 10 Personen rechnen, welche die Zeit des Beginns ihrer Krankheit nicht angeben können. Von diesen 88 Personen sind 25 in ihrer Kindheit erkrankt, einige aber auch als Erwachsene oder selbst als Greise.

Vor längerer Zeit erkrankt sind folgende: Vor 7—8 Jahren sind 27 Personen erkrankt, von welchen 9 zwischen 10- und 20 jährige. Dieselben sind also als Kinder von 6—10 Jahren erkrankt.

Vor 8—10 Jahren sind 24 Personen erkrankt, darunter 2 18- und 20 jährige.

Vor 11—15 Jahren sind 35 Personen erkrankt, darunter 5 zwischen 18 und 20 Jahre alt.

Seit 15—20 Jahren sind 23 Personen erkrankt.

Seit 20—25 Jahren sind 15 Personen erkrankt.

Seit 25—30 Jahren sind 8 Personen erkrankt.

Vor über 30 Jahren sind folgende erkrankt: eine Person seit 50 Jahren, eine andere seit 35; eine 50 jährige Person soll seit ihrer Kindheit erkrankt sein, ein 40 jähriger behauptet ebenfalls, seit frühester Kindheit krank zu sein.

Wir haben noch festzustellen gesucht, ob jene Personen länger leben, bei welchen die Krankheit in der Kindheit aufgetreten ist, als jene, bei welchen sie erst spät entstanden war, konnten aber keinen wesentlichen Unterschied erkennen.

Krankheitsform. Vermögensverhältnisse.

In betreff der Krankheitsform leiden von den jetzt lebenden Kranken 67 an Lepra tuberosa, 61 an Lepra nervosa, von denselben sind 24 als Lepra mutilans bezeichnet worden. Als Lepra mixta wurden 15 bezeichnet, während in den übrigen Fällen die Form der Lepra nicht angegeben ist.

Was die Vermögensverhältnisse der Leprösen betrifft, so sind gänzlich unbemittelt 109. Etwas weniger arm sind 41, wohlhabend sind 29, während von den übrigen keine Daten vorliegen. Hieraus folgt, dass zwar die meisten Leprösen arm sind, dass aber das Verhältnis zwischen arm und wohlhabend etwa dasselbe ist wie bei gesunden Personen. Hieraus kann aber keineswegs gefolgert werden, dass die Lebensweise nicht von Einfluss auf die Krankheit sei, da namentlich auf dem Lande auch die mehr bemittelte Bevölkerung sich schlecht nährt und unhygienisch wohnt.

Ursprung der Lepra, Familie, ektogener Ursprung.

Nachdem ich die Lepra als eine wesentlich familiäre Krankheit bezeichnet hatte, war es interessant, die rumämischen Leprösen daraufhin zu untersuchen, ob dieselben Lepröse in der Familie haben, oder ob sie mit anderen Leprösen zusammengewohnt haben. Wenn wir nur die Kranken, welche auf die diesbezüglichen Fragen geantwortet hatten, nämlich 245, in Betracht ziehen, finden wir, dass

in 18 Fällen der Vater leprös war
„ 9 „ die Mutter „ „
„ 16 „ „ Geschwister leprös waren
„ 4 „ „ Ehegatten „ „
„ 6 „ Onkel oder Tanten leprös waren
„ 5 „ die Kranken in derselben Wohnung mit Leprakranken (meist nahen Verwandten) wohnten
„ 1 „ Nachbarn leprös waren
„ 24 „ andere Lepröse in der Gemeinde waren

Im ganzen 83 Fälle, in welchen Kontakt mit Leprösen nachgewiesen wurde.

In 58 Fällen handelt es sich um lepröse Familien, wo also mehrere Familienmitglieder leprös waren.

Wir haben übrigens gesehen, dass fast in der Hälfte aller Leprafälle mehrere Lepröse in einer Gemeinde wohnen.

Diese Daten bestätigen demnach von neuem die Kontagiosität der Krankheit, namentlich im Schosse der Familie. Der Umstand, dass sich in anderen Fällen Familienmitglieder nicht infiziert haben, ist durchaus nicht als Gegenbeweis anzuführen, nachdem verschiedene, zum Teil unbekannte Umstände die Infektion verhüten konnten.

In Bezug auf die Frage, ob viele Lepra nicht aus dem russisch-türkischen Kriege stammen, haben wir nur wenig Angaben, was wohl damit zusammenhängt, dass die kurz nach dem Kriege Erkrankten zum grossen Teil schon gestorben sind.

Der Vater eines Leprösen hat den Krieg mitgemacht, ohne leprös zu sein; 2 Kranke behaupten, sich im Kriege infiziert zu haben.

In 12 Fällen ist angegeben, dass Traumatismus, Erkältung (Erfrierung) oder grosse Strapazen dem Ausbruch der Krankheit vorausgegangen waren.

II. Bekämpfung der Lepra in Rumänien.

Aerztliche Behandlung.

Von den gegenwärtig lebenden Leprösen waren 134 in ärztlicher Behandlung, während 142 nicht behandelt wurden, indem sie sich einer Behandlung entzogen. 125 Kranke waren von 20 Tagen bis zu mehreren Jahren in Krankenhäusern oder im Lepraasyl untergebracht, während etwa 10 Bemittelte ambulant von Aerzten behandelt wurden.

Die Behandlung war die übliche. Es wurden Bäder (Schwefelbäder), verschiedene Salben, namentlich Rohpetroleum, Chaulmoograöl innerlich und äusserlich gegeben, manchmal auch kakodylsaures Natron. Die Geschwüre wurden speziell behandelt und verbunden. Auch das Serum von Carasquilla wurde angeblich mit einigem Erfolge (?) angewendet.

Besonders Kranke, welche viel Chaulmoograöl vertragen konnten, zeigten auffallende Besserung aller Symptome.

Nachdem aber einesteils die Kranken in den verschiedenen Spitälern nicht oder ungenügend isoliert wurden und gewöhnlich dort nur kurze Zeit verblieben, können wir der Behandlung keine wesentliche Rolle in der Bekämpfung der Lepra zuerkennen.

Auch die häusliche Behandlung und Isolierung wurde nur ausnahmsweise konsequent durchgeführt, so dass im allgemeinen in den letzten Jahren von einer systematischen Bekämpfung der Lepra nicht gesprochen werden kann.

Wir haben gesehen, dass dementsprechend auch die Krankheit keineswegs zurückgegangen ist. Auch das Lepraasyl entspricht keineswegs seinem Zwecke.

Das Lepra-Asyl.

Das Lepra-Asyl Rachitósa ist ein vom Staate unterhaltenes Spital, welches in abgelegener hügeliger Gegend des Distriktes Tecuci in einem alten, hierzu eingerichteten Kloster untergebracht ist.

Das Spital hat 30 Betten, welche z. T. für Sieche (Apoplexien, Paralysien, Nephritiden etc.), z. T. für Lepröse bestimmt sind.

Die lepröse Abteilung ist von der anderen zwar abgeteilt, doch ist der Spitalshof nicht separiert und befindet sich hier die Kirche, welche von den Dorfbewohnern besucht wird.

Die Kranken werden gut genährt, gebrauchen Bäder und grosse Dosen Chaulmoograöl bis zu 18 Kapseln zu 1 g täglich. Jene, welche das Oel gut vertragen, werden auffallend gebessert, solche, die dasselbe nicht nehmen können, bekommen kakodylsaures Natron. Auch mittelst desselben wurden gute Resultate erzielt.

Wir haben gesehen, dass verhältnismässig wenig Kranke, höchstens 20—30, hier isoliert werden können, und bleiben dieselben verhältnismässig kurze Zeit. Namentlich wenn ihre Wunden geschlossen sind und der Allgemeinzustand besser wird, werden sie um so schneller entlassen, als sie kaum zu halten sind.

Allein im Jahre 1897—98 flohen aus dem Asyl von 20 Kranken 12, also mehr als die Hälfte, nach Hause!

In der Zeit von 1897—1903 verstarben im Asyl 21 Kranke.

Leider ist es bei der Abgelegenheit des Asyls schwer, zu demselben zu gelangen, um das wertvolle Material näher zu studieren.

Es konnte hier bloss konstatiert werden, dass mehrere Lepröse im türkisch-russischen Kriege des Jahres 1877 mit Kosaken zusammen verkehrten und angeblich von ihnen angesteckt wurden. In einem Falle behauptet ein seit 1897 erkrankter Mann, während des Krieges, also vor 20 Jahren, 3—4 Monate mit einem Don'schen Kosaken zusammen geschlafen zu haben.

Viele Umstände lassen es dringend nötig erscheinen, dass das Asyl in eine andere Gegend verlegt werde.

1. Befindet sich das Asyl schwer zugänglich in einer von den Lepraherden weit entfernten leprafreien Gegend. Allerdings wurden im letzten Jahre auch im Distrikt Tecuci 3 Leprafälle konstatiert.

2. Ist das Spital nicht isoliert, im Spitalshofe ist die Dorfkirche, und ein Teil des Spitales dient für andere Kranke, welche nicht genügend von den Leprösen getrennt sind.

3. Ein Lepra-Asyl für Rumänien müsste imstande sein, den grösseren Teil der Leprösen aufzunehmen, oder aber es müssten besser 2 Asyle, eines im gebirgigen Lepraherde, das andere im Distrikte Tulcea am Meere errichtet werden.

4. Die Kranken müssten gut genährt, gepflegt, beschäftigt und beaufsichtigt werden. Dieselben dürfen allerdings, wenn sie gebessert sind, wohl instruiert für kurze Zeit beurlaubt werden, indem die betreffenden Ortsgemeinden zugleich verständig werden, doch müssen sie veranlasst werden, immer wieder in das Asyl zurückzukehren, wo sie immer Platz, gütige Behandlung und Beschäftigung finden sollen.

Wir lassen umstehend die namentliche Liste der jetzt in Rumänien lebenden Leprakranken mit Angaben über Alter, Ort der Erkrankung, jetzigem Aufenthalt, Dauer der Erkrankung, Ort und Dauer der ärztlichen Behandlung, Kontakt mit anderen Leprösen, namentlich in der Familie, Art der Ansteckung, Form der Krankheit sowie Vermögensverhältnisse folgen.

Es ist zu wünschen, dass in Zukunft die genauere Kenntnis der Leprösen im Lande besser für die Bekämpfung der Krankheit verwertet werde als dies heute geschieht.

Besonders gefährlich ist es, aus falsch verstandenen Humanitätsgründen die radikale Isolierung der Kranken zu bekämpfen, wie dies hier z. T. selbst von leitender Stelle aus geschieht.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann is krank, wie is selbe erkran irgend ein V mit den R während Krieges 187 stattgefun
1	Ilie Gh. Ghelabonia, 13 Jahre, männlich.	Ledig.	Arges, Berislavesti.	Arges, Berislavesti.	Hier geboren.	—	Seit 2 Jahren Vater hat gedient.
2	Dumitra J. S. Gabata, 18 J., weibl.	do.	Arges, Urlnesti-Babeni.	Arges, Urlnesti-Babeni.	do.	—	Seit etwa 5 Ja d. Vater hat gedient.
3	Dumitra P. Onescu, 32 J., männl.	Vereh.	Arges, Dangesti.	Arges, Dangesti.	do.	—	Seit 19 Jah
4	Sanda J. Joan, 28 J., weiblich.	do.	do.	do.	do.	—	Seit 10 Jah
5	Sandu Calin, 54 J., männlich.	do.	do.	do.	do.	—	Seit 8 Ja keine Berü mit den R
6	Dumitra J. Mitrai, 44 J., weiblich.	do.	Arges, Urlnesti.	Arges, Urlnesti.	do.	—	Seit 1875; Berührung den Russe
7	Maria J. Vladulus, 18 J., weibl.	do.	Arges, Salatrucul.	Arges, Salatrucul.	do.	—	Seit 1894; i
8	Jamandi E. Tache, 42 J., männlich.	do.	Arges, Cepari.	Arges, Cepari.	do.	—	Seit 1874; i
9	Tudor Stroescu, 25 J., männlich.	do.	Arges, Tedelesoni-Feteni.	Arges, Tedelesoni-Feteni.	do.	—	Seit 1876; i
10	Maria Preuteasa Balasa, 60 J., weiblich.	do.	Arges, Oesti.	Arges, Oesti.	do.	—	Seit 1852; i

...t. schon ärztlich ...andelt worden, ..., wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
	Nein. Eltern und andere Geschwister gesund.	—	Die Krankheit begann mit einer allgemeinen Eruption, es folgten Leprome am Ellenbogen, später auch an den Beinen. Seit 3—4 Monaten näselnde Stimme. Das Gesicht ist charakteristisch, die Nase eingefallen und verdickt, ebenso die Gesichtshaut. Die erbsen- bis haselnussgrossen Leprome sind rötlich.	Bemittelt.
	Der Vater war leprös und starb vor 12 Jahren (45 J. alt). Pat. wohnt zusammen mit ihrer Tante Jouna Gabuta. In derselben Gemeinde wohnt die Lepröse Dumitra J. Mihail.	—	Schwellung des Gesichts, mit rauher, verdickter und glänzender Haut. Eingefallene, verbreiterte Nase. Oberlippe verdickt. Am Velum palatium rechts 2 cm grosse Ulzeration, ebenso ulzeriert die linke Tonsille. Rechte Hand beginnt krallenförmig zu werden. Tuberkel, Geschwülste und Narben an sämtlichen Extremitäten.	Aeusserst arm.
	In derselben Gemeinde wohnen noch die Leprösen Sanda J. Joan und Sanda Calin; ein dritter Lepröser, G. Manolin, starb vor 6 Jahren.	—	—	Arm.
... kurze Zeit im ...ıkenhaus zu ...i.	Behauptet, dass ihr Vater leprös gewesen; in demselben Dorfe 3 Lepröse, von welchem der eine verschieden.	—	—	Arm.
... einen Monat im Kranken- ... Rimnic-Vîlcei.	Keine leprösen Verwandten. Im Dorfe wohnen Leprakranke.	—	—	Arm.
... in das Lepro- ...ım Rachitrasa ...eliefert.	Ihre Brüder und Schwestern sollen infolge der Lepra gestorben sein.	—	—	Arm.
... im Kranken- ...se Bûncoreann ...ukarest behand.	—	—	—	Arm.
...Zeit i. Kranken- ...se zu Rîmnic- ...a.	—	—	—	Arm.
	—	—	—	Bemittelt.
	—	—	—	Nicht arm.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist krank, wie is selbe erkrank irgend ein Ve mit den Ru während Krieges 187 stattgefund
11	Florica J. D. Comanescu, 43 J., weiblich.	Vereh.	Arges, Alimanesti Ciofrîngeni.	Arges, Alimanesti Ciofrîngeni.	Wohnte einige Zeit in Tutana, wo sie angeblich erkrankt sein soll.	—	Seit 1895; i
12	Maria J. Tudor, 30 J., weiblich.	„	Arges, Corbeni.	Arges, Corbeni.	Hier geboren.	—	Seit 5 Jahre
13	Anica A. D. Uta, 23 J., weiblich.	„	Arges, Vernesti.	Arges, ValeaDannbu.	Gesund aus Valea Dannbu zugezogen.	—	Seit 1898.
14	Zamfir N. F. Nutr, 21 J., männlich.	Ledig	Arges, Vernesti.	Arges, Vernesti.	Hier geboren.	—	Seit 1898.
15	Joana St. Gabur, 21 J., weiblich.	Vereh.	Arges, Urlnesti.	Arges, Urlnesti.	do.	—	Seit 1894: e Brud. hat d rum.-türk. mitgemach aber gesu
16	George J. Nicolete, 21 J., männlich.	Ledig	Arges, Salatone.	Arges, Salatone.	—	—	Seit 10 Jal
17	Maria N. Olteanu, 30 J., weiblich.	„	Arges, Boráslávesti.	Arges, Boráslávesti.	—	—	Seit 16 Jal
18	Mucenic, J. M. Teodor, 9 Jahre, männlich.	Schül.	Arges, Corbeus	Arges, Corbeus	Hier geboren.	—	Seit 1900.
19	Vasile Neagoie, 24 J., männlich.	Verehel.	Arges, Corbeus Cipatina.	Arges, Corbeus Cipatina.	do.	—	do.

. schon ärztlich ıdelt worden, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
Zeit im Kranuse Curtes de	Keine leprösen Verwandten.	—	Die Krankheit—Lepra tuberosa — begann mit gastrischen Störungen, Muskel- und Gelenkschmerzen. Darauf folgt Verdickung der Haut an den entblössten Körperteilen. 1897 Auftreten von schmerzlosen harten Knoten, umgeben von verdickter, dunkler Haut, an der Nase, den Lippen und Armen. Die Knoten am Gesichte sind ulzeriert. — 1898 im Leprosorium Rachitonsa eingeliefert.	Arm.
Zeit im Kranuse Curtes de	Keine leprösen Verwandten; im Dorfe wohnte die nun verstorbene Lepröse Florica Andrean.	—	—	Arm.
—	Keine leprösen Verwandten; kennt den leprösen Zamfir Nita Nutu, ist aber mit demselben — der ebenfalls in Vernesti wohnt — nicht in nähere Berührung gekommen.	—	Die Krankheit—Lepra tuberosa — begann mit Schwellung der Nase. Leprome an der Stirn, an den Armen; Geschwür am Velum palatinum.	Nicht arm.
—	Keine leprösen Verwandten.	—	—	Nicht arm.
—	Keine leprösen Verwandten. Wohnt in der Nachbarschaft der Leprösen Dimitra J. Mitrai.	—	—	Arm.
—	Keine leprösen Verwandten.	—	Nase entstellt; Nasalknochen atrophisch. Knoten im Gesicht, Geschwüre an den Extremitäten, Mal perforant; zahlreiche Narben an den Extremitäten; Finger der rechten Hand in Hammerform. Tastgefühl verringert bes. an den oberen Extremitäten.	Arm.
—	Keine leprösen Verwandten.	—	Atrophie der Handmuskeln; an den Fingern Narben. Zehen atrophisch. Tastgefühl bes. an der rechten Hand verringert.	Nicht arm.
·ehandelt.	Mutter ist leprös.	—	Die Krankheit begann mit Schwellung des Gesichtes. Es folgten Knoten am Gesicht, Armen und Beinen, die jetzt in grosser Anzahl vorhanden sind. Entstellte Nase. Näselnde Sprache.	Arm.
do.	Sein Vater — vor 11 Jahren gestorben — scheint an Lepra gelitten zu haben.	—	Die Krankh. begann mit Geschwüren, die zuerst am r. Unterarm, dann auch links und an den Unterschenkeln auftraten.	do.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann is[t] krank, wie is[t] selbe erkran[kt] irgend ein Ve[rkehr] mit den R[ussen] während Krieges 187[7] stattgefun[den]
20	Joana P. C. Cican, 24 J., weiblich.	Verehel.	Arges, Corbeus	Arges, Corbeus	Hier geboren.	—	Seit 1897.
21	Petrus J. Straut, 30 J., männlich.	do.	do.	do.	do.	—	Seit 6—7 J.
22	GeorginaP. Tanase 30 J., weiblich.	do.	Arges, Bascov.	Arges, Slationrele.	Zugezog., dam. ges. gewesen.	—	Seit 8 Jahr
23	Maria N. Mihae, 52 J., weiblich.	do.	Arges, Valea Damulus.	Arges, Curtea de Arges.	Gesund zugezogen.	—	Seit 6—7 J
24	Joita M. Gherasiu, 48 J., weiblich.	Ledig.	do.	Arges, Valea Domnulus.	Hier geboren.	—	Seit etwa
25	Nicolae J. Nicu, 44 J., männlich.	Verehel.	Arges, Allosti Bralesti.	Arges, Allosti Bralesti.	do.	—	Seit etwa 2
26	Georg M. Ilea, 39 J., männlich.	do.	Arges, Salatruc.	Arges, Salatruc.	do.	—	Seit 8 Jah
27	Mita M. Pottelnicescu, 23 Jahre, weiblich.	do.	Arges, Mosania	Arges, Sapata de Sus.	Gesund zugezogen.	—	Seit 5 Jah
28	Maria Cr. Carareaza, 18 J., weibl.	Ledig.	Braila, Ceacaru.	Braila, Ceacaru.	Hier geboren.	—	Seit 1895.
29	Panoite Dimofte, 30 J., männlich.	do.	Braila, Strambu.	Braila, Strambu.	do.	—	Seit 1899.
30	Archile Dimofte, 16 J., männlich.	do.	do.	do.	do.	—	Seit 1895.
31	Anica G. Stoica, 55 J., weiblich.	Verh.	Braila, Islaz.	Braila, Cazura.	Gesund zugezogen.	—	—
32	Sita T. Manea, 25 J., weiblich.	Ledig.	Braila, Ceacaru.	Braila, Ceacaru.	Hier geboren.	—	Seit 1900.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
Nicht behandelt.	Keine leprösen Verwandten.	—	—	Arm.
do.	do.	—	Amputation d. Finger. Bärentatzen.	—
1902 im Krankenhaus zu Pilasti.	do.	—	Knoten.	Arm.
Hat sich in Bukarest (Coltea- und Brincoveanu-Krankenhaus) vorgestellt (1902).	Wohnte vor ihrer Erkrankung mit einer leprösen Schwägerin zusammen.	—	Lepra mutilans, begann mit Jucken, m. darauffolg. Leprom. Eingefallene Nase. Augenbrauen nicht mehr vorh. Atrophie d. Nn. optici.	do.
Nicht behandelt.	Wohnte zusammen m. der Pat. No. 23.	—	Lepra mutilans. Leprome, teilw. ulzer., an den oberen und unteren Extremität.	do.
Vor 6 Jahren i. Coltea-Krankenhaus.	—	—	Lepra mutil. Amputation dreier Finger.	Nicht arm.
Nicht behandelt.	Sein Vater war gesund, hat den Krieg mitgemacht. Patient kennt Lepröse u. war in Berühr. mit der Lepròs. Maria J. Vlad.	—	Die Krankheit begann mit Blasen, die geplatzt sind. Amputationen d. Finger u. Zehen. Narben und Kontrakturen.	do.
Vielfach privat behandelt, ohne dass ihr Leiden diagnostiziert worden wäre.	Keine leprösen Verwandten.	—	Die Krankheit begann mit Kopfschmerzen und Sensibilitätsstörungen an Händen und Füssen. Es folgten Blasen, Einsinken der Nase, Difformation des Gaumens, Heiserkeit, erbsen- bis haselnussgrosse Leprome, Mal perforant.	Bemittelt.
1896 im Krankenhaus Vizirn behandelt.	Glaubt von ihrer leprösen (†) Schwester infiziert zu sein.	—	—	Arm.
1894 im Coltea-Krankenhaus gewesen.	Ein Bruder und eine Schwester seines Vaters sollen leprös gewesen sein; sein jüngerer Bruder ist leprös.	—	—	Nicht arm.
Nicht behandelt.	Wahrscheinlich von seinem Bruder infiziert. S. No. 29.	—	—	Nicht arm.
do.	—	—	Lepra trophoneurotica.	Nicht arm.
1901 und 1903 im Krankenhaus Vizirn gewesen.	Keine leprösen Verwandten.	—	—	Nicht arm.

nänien.

	...ursort ...rk. ...emde:	...ursort ...rk. ...emde:	... Wohnort gewohnt oder ist er von einem anderen Ort zugewandert? Woher?	Wann Pat. bereits krank, als er sich in diesem Orte niederliess?	Seit wann ist Pa... krank, wie ist de... selbe erkrankt, h... irgend ein Verke... mit den Russe... während des Krieges 1877—... stattgefunden?
[illegible]	[illegible]	...lamme Saran... ...nu.	Gesund zu- gezogen.	—	Vor 2 Jahren.
[illegible]	[illegible]	—	—	—	—
[illegible]	...sen. ...arlagete.	...zen. ...arlagete.	Hier geboren.	—	Pat. weiss es nich... genau.
[illegible]	[illegible]	...zen. ...ula.	...	—	io.
[illegible]	[illegible]	...zen. ...ra ...us.	...	—	Seit 2 Jahren.
[illegible]	[illegible]	...zen. ...anesti.	...	—	Seit 6 Jahren.
[illegible]	[illegible]	...uzen. ...eraei.	...	—	Seit 1893.
[illegible]	[illegible]	...rana. ...enii.	Gesund zu- gezogen.	—	Seit 1897.
[illegible]	[illegible]	...nstanta. ...mirteni.	Hier geboren.	—	Seit 1894.
[illegible]	[illegible]	...nstanta. ...aia.	Krank zu- gezogen.	—	Seit 1894. In se... nem Geburtso... war das russisc... Armeequartier.
[illegible]	[illegible]	Constanta. ...lava Rusa.	Gesund zu- gezogen.	—	Seit 1899.
[illegible]	[illegible]	...ulcea. ...ulcea.	io.	—	Seit einem Jahr Keine Berühru... mit den Russe...
[illegible]	[illegible]	Constanta. Gârliciu.	io.	—	Seit 1897.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
1903 im städtischen Krankenhaus zu Braila.	Keine leprösen Verwandten.	—	—	Nicht arm.
—	—	—	—	—
1896 im Krankenhaus zu Patarlajeb gewesen.	Keine leprösen Verwandten.	—	Wohnt jetzt in Surana (Praheon).	Nicht arm.
Ist Soldat gewesen, hat den Krieg mitgemacht. (1901 im Krankenhause zu Buzen gewesen).	do. Glaubt im Kriege infiziert worden zu sein.	—	—	Nicht arm.
Nicht behandelt.	Keine leprösen Verwandten. Seit 6 Monaten bettlägerig.	—	—	Arm.
Ihr Gatte, † 1886, hat den Krieg mitgemacht und ist leprös gewesen. In ärztlicher Privatbehandlung.	Ein Kind aus erster Ehe war leprös und starb. Ihr jetziger Mann, mit dem sie seit 17 Jahren zusammenwohnt, ist gesund.	—	—	Bemittelt.
1895 im Krankenhause zu Cerna Voda behandelt.	Ein Bruder ist ebenfalls leprös.	—	Lepra tuberosa.	Nicht arm.
1899 im Krankenhause zu Cerna Voda behandelt.	—	—	Lepra mutilans, trophoneurotische Störungen.	Bemittelt.
—	—	—	Lepra mixta.	Nicht arm.
In den Krankenhäusern Coltea und Brincoveanu öfters behandelt. 1895 Amputation des rechten Fusses.	Keine leprösen Verwandten.	—	Lepra tuberosa.	—
Nicht behandelt.	S. No. 39. Von seinem Bruder infiziert.	—	—	Bemittelt.
do.	Keine leprösen Verwandten.	—	Lepra tuberosa.	Nicht arm
1899 im Krankenhaus zu Bobady gewesen.	Keine leprösen Verwandten. Pat. gibt an, dass die Erkrankung sich an eine Erfrierung anschloss. Ein lepröser Bruder starb 1895.	—	Lepra ulcero-tuberosa (Rachitonsa).	Nicht arm.

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46	Constanta Jemlet, 45 J., weiblich.	Verh.	Covurleine, Galatz.	Covurleine, Galatz.	Hier geboren.	—	Seit 1895.
47	Liza Silbermann, 19 J., weiblich.	Ledig.	do.	Jassy, Jassy.	Gesund zugezogen.	—	Seit 1898.
48	Ifrius Nichifor, 47 J., männlich.	Verh.	do.	Bassarabien, Jobriaz.	Krank zugezogen.	—	Seit 2 Jahren.
49	Dobre Radu, 45 J., männlich.	Witwer.	Dâmbrosta, Cernesti.	Dâmbrosta, Cernesti.	Hier geboren.	—	Seit 1882. Ist dat gewesen hat den K mitgemacht.
50	Ilinaa J. M. Branisteann, 26 J., weiblich.	Verh.	do.	do.	do.	—	Seit 1895.
51	Anica J. Dinn, 38 J., weiblich.	do.	Dâmbrosta, Raciu.	Dâmbrosta, Raciu.	do.	—	Seit 1887.
52	Joana N. Slanoin, 26 J., weiblich.	Ledig.	Dambovita, Pietzari.	Dambovita, Pietzari.	Hier geboren.	—	Seit 1892.
53	Nicolae N. Slanoin, 16 J., männlich.	do.	do.	do.	do.	—	Seit 1895.
54	George S. Stoica, 66 J., männlich.	Verh.	Dambovita, Cähenu.	Dambovita, Cähenu.	do.	—	Seit etwa 6 J
55	George Mitrous, 20 J., männlich.	Ledig.	Dambovita, Titu.	Dambovita, Titu.	do.	—	Seit 1897.
56	Neagu Constantin, 26 J., männlich.	do.	Dambovita, Dobra.	Dambovita, Dobra.	do.	—	Seit 1899.
57	Maria J. Bann, 16 J., weiblich.	do.	Dambovita, Cuipa.	—	—	—	—
58	Haicu M. Joan, 28 J., männlich.	Verh.	Doljiu, Nedeia.	Doljiu, Nedeia.	Hier geboren.	—	Seit 1891.
59	Maria St. Gaina, 47 J., weiblich.	Ledig.	Doljiu, Ceratu.	Doljiu, Ceratu.	do.	—	Seit 1877.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
1897 im Krankenhaus St. Spiriden zu Galatz.	Keine leprösen Verwandten. Pat. ist Wäscherin.	—	—	Arm.
Nicht behandelt.	Keine leprösen Verwandten.	—	—	Nicht arm.
Kurze Zeit in den Krankenhäusern zu Sulina und Chilia veche in Behandlung gewesen.	do.	—	—	Bemittelt.
1894 und 1896 in den Krankenhäusern zu Brîncoveanu und Coltea behandelt.	Keine leprösen Verwandten. In seinem Dorfe sind noch andere Lepröse vorhanden.	—	—	Arm.
Nicht behandelt.	Keine leprösen Verwandten. S. No. 49.	—	—	Nicht arm.
1897 im Brincoveanu-Krankenhause sowie im Spitale zu Tìrgevestu in Behandlung gewesen.	Keine leprösen Verwandten.	—	—	Arm.
1897 im Krankenhaus zu Voinesti in Behandlung gewesen.	Der Vater soll leprös gewesen sein; ein Bruder leidet an Lepra. S. No. 53.	—	Die Krankheit begann mit einer Schwellung der unter. Extremitäten.	Arm.
1897 im Krankenhaus zu Voinesti.	S. No. 52.	—	—	do.
1897 im Krankenhaus Cocive, 1898 im Krankenh. Brincoveanu.	Keine leprösen Verwandten.	—	Die Krankheit begann mit Blasen, die vereiterten, vergingen u. von neuem auftraten. Lepra tuberosa. Viele vereit. Knoten. Pat. ist infolge Zerstörung der beiderseit. Bulbi vollständig erblindet.	Bemittelt.
1898 im Krankenhaus zu Tirgovester.	do.	—	Die Krankheit begann mit einer Schwellung d. Gesichts u. d. Hals.	Nicht arm.
1901 im Krankenhaus Brincoveanu i. Bukarest.	do.	—	Ist während d. Militärdienstes erkrankt.	do.
—	—	—	—	—
1891 oder 1892 im Krankenh. Brincoveanu sowie in den Spitälern zu Filiasi, Bailesti und Craieva („Philanthropia").	Es ist Verdacht vorhanden, dass ein 1890 verstorbener Bruder an Lepra gelitten habe.	—	—	Arm.
Im Brincoveanukrankenh. zu Bukarest.	—	—	—	do.

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0	Dina Marin, 13 J., weiblich.	Ledig.	Doljiu, Macesul de jos.	Doljiu, Macesul de jos.	Hier geboren.	—	Seit 1896.
1	Petre M. Dobre. 36 J., männlich.	Verh.	Doljiu, Catave.	Doljiu, Catave.	do.	—	Seit 1891.
2	George P. M. Dobre. 9 J., männlich.	—	Doljiu, Catave.	Doljiu, Catave.	do.	—	Seit 1897.
3	Maria G. Farziu. 17 J., weiblich.	Ledig.	Doljiu. Rastiu.	Doljiu, Rastiu.	do.	—	Seit 1897.
4	Costica Marinescu. 26 J., männlich.	Verh.	Doljiu. Craiova.	Doljiu. Craiova.	do.	—	Seit 1898.
5	Mihaela Dumitru, 28 J., weiblich.	do.	do.	do.	do.	—	Seit 1899.
6	Stefan J. Dumitru, 15 J., männlich.	Ledig.	Doljiu. Doloridor.	Doljiu. Doloridor.	do.	—	Seit 1900.
7	Joan M. Sirbu, 30 J., männlich.	Verh.	Doljiu. Cetatea.	Doljiu. Cetatea.	do.	—	Seit 1895.
8	Florea Spatarel, 38 J., männlich.	do.	Doljiu. Locusteni.	Doljiu. Locusteni.	—	—	—
9	Joan D. Dragomor, 23 Jahre, männlich.	Ledig.	Doljiu. Macesu de Jos.	Doljiu. Macesu de Jos.	do.	—	Als 11 jährig Junge erkran
0	Joan D. Caosila Tucu, 36 Jahre, männlich.	Verh.	do.	do.	do.	—	Seit 8 Jahren.
1	Stancu Camin, 61 J., männlich.	do.	do.	do.	do.	—	Seit 16 Jahre
2	Dina M. S. Sanda, 19 J., weiblich.	Ledig.	do.	do.	do.	—	Seit 3 Jahren.
3	Joana J. P. Criveanu, 18 J., weibl.	do.	do.	Doljiu. Jui de jos.	Gesund zugezogen.	—	—
4	Maria B. Casacu, 30 J., weiblich.	Verh.	Doljiu. Balta.	Doljiu. Balta.	do.	—	Seit 2 Jahren.
5	Petrus J. Balistaru Valeoteanu, 70 J., männlich.	Ledig.	Gorj. Arcanii.	Mehedinti. —	do.	—	Seit 6 Jahren.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
1898 im Philantropiakrankenh. zu Oricva.	—	—	Lepra tuberosa.	Arm.
1899 im Krankenhaus Bailesti.	Ist von seiner leprös. Frau, die 1893 †, infiziert worden.	—	do.	do.
1899 im Krankenhause zu Bailesti.	Kind lepröser Eltern. S. No. 61.	—	—	do.
do.	Keine leprösen Verwandten.	—	Lepra tuberosa.	Nicht arm.
1891 im Philanthropia-Krankenhaus zu Croicon, ebenso im Krankenhaus „Preda".	Keine leprösen Verwandten. Pat., Schuhmacher, gibt an, bei einem Meister in Caracal gearbeitet zu haben, wo er mit einem wahrscheinlich leprösen Gesellen zusammenschlief.	—	Lepra tuberosa.	—
Nicht behandelt.	—	—	—	Nicht arm.
do.	Ein nun verstorbener Bruder litt an Lepra.	—	Lepra tuberosa. Knoten an den Extremitäten, am Gesicht, an der Stirn, Nase und Gaumen. An den Beinen einige ulzerierte Knoten.	Bemittelt.
1895 und 1896 in den Krankenhäusern Calatat und Bailesti.	Keine leprösen Verwandten.	—	—	Arm.
—	—	—	—	Nicht arm.
Nicht behandelt.	Sohn einer Leprösen, die kurz nach der Geburt gestorben ist.	—	—	Arm.
do.	Keine leprösen Verwandten.	—	—	Arm.
Im Krankenhaus Philanthropia in Craiova.	do.	—	—	Arm.
Id. id.	do.	—	—	Nicht arm.
Nicht behandelt.	do.	—	—	Nicht arm.
do.	—	—	—	Nicht arm.
do.	Hat seine Eltern nicht gekannt u. kann keine Angaben machen über das Entstehen der Krankheit.	—	—	Arm.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann is krank, wie is selbe erkranl irgend ein Ve mit den Ri während Krieges 187 stattgefun
76	George Baloin, 39 J., männlich.	Verh.	Gorj, Arcani.	Gorj, Arcanii.	Hier geboren.	—	Seit 1895.
77	Dumitra Grozoin, 28 J., männlich.	do.	Gorj, Stroesti.	Gorj, Stroesti.	do.	—	Seit 1892 1893.
78	Marina V. G. Dijmarescu, 45 J., weiblich.	do.	Gorj, Horezu.	Gorj, Schela.	Gesund zugezogen.	—	Seit 1885.
79	NicolaeJ.Panesen, 16 J., männlich.	Ledig.	Gorj, Carpenis.	Gorj, Carpenis.	Hier geboren.	—	Seit 4 Mon
80	Joan Puite, 40 J., männlich.	Verh.	Gorj, Arcanii.	Gorj, Arcanii.	do.	—	Seit 4 Jahr
81	Dumitra D. Balan, 35 J., männlich.	do.	do.	do.	do.	—	Seit 1903.
82	Lache Aughelenu, 23 J., männlich.	Ledig.	Jalamita, Ciuluita.	Jalamita, Ciuluita.	do.	—	Seit 1891.
83	Trifu Costache, 21 J., männlich.	Vereh.	Jalamita, Rasa.	Jalamita, Rasa.	do.	—	Seit 3 Jah
84	Christache Stan Trifu, 46 J., männlich.	do.	do.	do.	do.	—	Seit etwa 3
85	Stan Bobescu, 20 J., männlich.	Ledig.	Jalamita, Burdusani Mari.	Salamita, Burdusani Mari.	do.	—	—
86	Staian Ivan, 27 J., männlich.	Vereh.	Jalamita, Ceacu.	Jalanita, Ceacu.	do.	—	Seit 2 Jahr
87	Traian Aughel, 27 J., männlich.	Ledig.	Jasy, Jasy.	Jasy, Jasy.	do.	—	—
88	Gheorghe Dragonur, 76 J., männl.	Witwer.	Ilfor, Bukarest.	Ilfor, Bukarest.	—	Hier geboren.	Seit 30 Jah
89	Christache Stoua, 30 J., männl.	ledig	do.	do.	—	do.	Seit 1891.
90	Zaharia Falik, 45 J., männl.	vereh.	do.	Bacau, Bacau.	—	Von Bacau gekommen.	Im Krieg erk und zwar Angabe de durch alte der — in Lo lanka.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
1899 im Krankenhaus zu Tirgu-Jiu.	Keine leprösen Verwandten.	—	—	Bemittelt.
1895 id. id.	do.	—	—	Arm.
Privatärztliche Behandlung.	do.	—	Lepra mutilans. Amputation der Finger und Zehen.	Bemittelt.
Nicht behandelt.	Keine leprösen Verwandten.	—	—	Nicht arm.
do.	Keine leprösen Verwandten. Pat. ist Tuchweber und viel auf Reisen. Im Dorfe sind noch andere Lepröse vorhanden.	—	Die Krankheit begann mit Geschwüren an Händen und Beinen und nachfolgender Anästhesie.	Nicht arm.
do.	Keine leprösen Verwandten und weiss nicht, dass er in derselben Wohnung mit Leprakranken gewohnt hat. In Gem. Arcani gibt es noch 3 Leprakranke.	—	—	Arm.
In Behandlung in Bukarest.	Keine leprösen Verwandten.	Weiss nichts anzugeben.	—	Nicht arm.
War 2 Monate in dem Krankenhaus zu Calarasch.	Der Vater ist 5—6 Monate vor ihm erkrankt. Keine weiteren Krankenfälle in der Familie.	—	—	Bemittelt.
Ist 3 mal in ärztlicher Behandlung gewesen.	Sein Sohn ist jetzt leprakrank, keine weiteren Krankenfälle in der Familie.	—	—	Bemittelt. Der Pat. hat viele Russen (Lipovenen), die oft ins Dorf kommen, als Freunde.
—	—	—	—	—
Nicht behandelt.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Nicht arm.
In Behandlung vom 7. Novbr. 1897 bis 25. März 1898 in der Univ.-Hautklinik zu Jassy.	—	—	—	—
2 mal in ärztlicher Behandlung.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Arm.
In der Hautklinik.	Der Vater soll krank gewesen sein.	do.	—	Bemittelt.
Behandl. in der Univ.-Haut-Klinik zu Bukarest.	Keine Kranken in der Familie.	do.	Lepra mixta.	do.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann i[s] krank, wie i[st er] selbe erkran[kt], irgend ein V[erkehr] mit den R[ussen] während [des] Krieges 187[7] stattgefun[den]?
91	Radu Sinnonescu, 60 J., männl.	Wit-wer.	Ilfor, Bukarest.	Salomits, Rasa.	Von Rasa.	Gesund zugezogen von Rasa.	Seit 1877. weiter. An[...]
92	Ecaterius Georgescu, 24 J., weibl.	Vereh.	Ilfor, Castranesti.	Ilfor, Hagiesti Mapintza.	Von Catrunesti.	—	Seit 1887 k[...]
93	Stau Preotis D. Niculas, 24 J., männl.	Ledig.	Ilfor, Colibasch.	Ilfor, Colibasch.	—	Hier geboren.	Seit 1886.
94	Nitza Pavel, 45 J., männl.	Vereh.	Ilfor, Ulmi.	do.	Von Ulmi.	do.	Seit 1879. [wäh]rend des K[rieges] 1877-78 a[...] dat hatte e[...] Artic. Rh[euma]tism.
95	Tudor Sonita, 46 J., männl.	do.	Ilfor, Turbati.	do.	Von Turbati.	do.	Seit 1890. als Fuhrm[ann] Kriege vo[n] bis 1878.
96	Alexe Dtru Stoica, 35 J., männl.	do.	Ilfor, Päroaka.	Dambovitz, Titis.	—	Von Titis.	Seit 1891.
97	Pavel Stamati, 43 J., männl.	do.	Ilfor, Bukarest.	Putna, Namoloasa.	Von Namoloasa.	Gesund n. Bukarest gekommen.	Seit 1887.
98	Mihail Nitulescu, 28 J., männl.	do.	do.	Ilfor, Bucarest.	War in St. Petersburg von wo er krank zurückkehrte.	Hier geboren.	Seit 1894 1895, als St. Peter[sburg] war, kam [...] nach Buk[arest] 1897.
99	Marcu Lazar, 59 J., männl.	do.	do.	do.	—	do.	Seit 1891.
100	Gheorghe Jon Dumitru Vasile, 19 J., männl.	Ledig.	Ilfor, Colibaschi.	Ilfor, Lipiia.	Von Lipiia.	—	Weiss nicht [...] stimmen.

…chon ärztlich …elt worden, …ie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
	Sein Vater war ebenso krank und sein Bruder ist auch krank.	Weiss nichts anzugeben.	—	—
r 15 Tage im ıhaus Coltza st.	Keine Kranken in der Familie.	do.	—	—
st 1894 war Monate im ahaus Brin- ı.	Die Eltern waren nicht leprakrank. Hatte 2 Brüder, die an Lepra starben. 2 andere sind gesund.	Hat die Krankheit von seinem älteren Bruder (Nikolaus) bekommen.	Lepra tuberosa.	Nicht arm.
var er 1 Monat ncoveanu- l.	Keine Kranken in der Familie.	Als Soldat wurde er in 1877-78 mit gefangen. Türken nach Bukarest geschickt, auf dem Wege hat er sich erkältet und nach 1 Jahr fühlte er an verschiedenen Stellen des Körpers Beulen.	Lepra trophoneurosa.	Bemittelt.
zw. im Jahre 894 u. 1896 im Hospital zi (4 Monate), l und 1895 ıkovean-Hos- in 1896 u. ı Branko- Iospital.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	Lepra tuberosa.	Arm.
3 Wochen im ıhaus von ste. In 1893 ɜ im Militär- l und 1 Mo- Krankenhaus ·canu i. Jahre ler 1894.	do. Er hat 5 Kinder, die alle gesund sind.	do.	Lepra mixta.	—
war er 2 bis im Hospital ıa, in 1896 in d. Univ.- ıik.	Keine Kranken in der Familie.	do.	do.	Bemittelt.
e behandelt, ırte er wieder Petersburg.	Wahrscheinlich sein Vater.	do.	do.	—
ıal in ärzt- ɪehandlung.	Keine Kranken in der Familie.	do.	—	Arm.
handelt.	do.	do.	—	—

	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige ...rös, welche, sah ...n seinem Wohn- ...sonstwo einen Erkrankten, ...derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
	in d.	Weiss nichts anzugeben.	—	—
		do.	—	—
		do.	—	—
	do.	do.	Lepra tuberosa.	Bemittelt.
zu	do.	do.	do.	Arm.
	do.	do.	do.	—
	do.	do.	do.	—
	do.	do.	do.	—
	—	—	—	—
	—	—	—	—
n- .	Hatte 2 Brüder die an Lepra gestorben sind.	Wahrscheinlich v. den Brüden angesteckt.	Lepra tuberosa.	Arm.
ne	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Bemittelt.
les t.	do.	do.	—	—
it-	Der Vater an Lepra gestorben.	Von seinem Vater angesteckt.	—	—
	Keine Kranken in der Familie.	Weiss nichts anzugeben.	Lepra tuberosa.	Arm.
	do.	do.	do.	do.
en- re.	do.	do.	do.	do.
	Vater und Bruder leprakrank.	Angesteckt von Vater und Bruder.	Lepra mixta.	Nicht arm.
les nia ne.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Arm.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877– stattgefunden
101	Anastase Christidi, 42 J., männl.	Ledig.	Ilfor, Bukarest.	Griechenland.	—	Von Griechenland zugezogen	Pat. giebt an sund gekomn zu sein, sche aber früher kr gewesen zu se Keine Berühr mit der R Armee.
102	Dobra Neagu, 47 J., weibl.	Vereh.	Ilfor, Lipia Bojdan.	Ilfor, Lipia Bojdan.	Hier geboren.	Hier geboren.	Seit 6 Jahren.
103	Brana Blumenfeld, 60 J., weibl.	Witwe	Ilfor, Bukarest.	Ilfor, Bukarest.	do.	Ist in Pitesti gewesen und dort erkrankt	Seit 6 Jahren.
104	Smaranda Jou, 45 J., weibl.	—	do.	do.	—	—	—
105	Dimitrie Nicolaides, 32 J., männl.	Vereh.	Ilfor (Sulna), Foesam.	Rumelien, Burgas.	—	Von Tulcea zugezogen	Seit 1894.
106	Stoika Jonita, 55 J., männl.	do.	Ilfor, Brezoia.	Ilfor, Brezoia.	Hier geboren.	—	Seit 3 Jahren
107	Anica Jon Nicolai, 26 J., weibl.	do.	Ilfor, Bojdani.	Ilfor, Bojdani.	do.	—	Seit 2 Jahren
108	Jordache Nicolai, 21 J., männl.	do.	Ilfor, Balaceanka.	Ilfor, Balaceanke.	do.	—	Seit 1898.
109	Jon Radu, 28 J., männl.	do.	Ilfor, Vartoss.	Ilfor. Vartoss.	—	—	—
110	Joana Jon, 13 J., weibl.	Ledig	Ilfor, Cocia.	Ilfor, Cocia.	Hier geboren.	—	—
111	Stan Popescu, 22 J., männl.	Vereh.	Ilfor, Colibarch.	Ilfor, Colibarch.	do.	—	Seit 11 oder Jahren.
112	Ecaterina M. Staucu, 27 J., weibl.,	do.	Ilfor, Hagiests.	Ilfor, Hagiesti.	do.	—	Seit 1889.
113	Stocia Mihael, 30 J., männl.	Ledig.	Ilfor, Bukarest.	Prabova, Duzesti.	—	gesund zugezogen.	Seit 1899.
114	Alexandro Spiridou, 23 J., männl.	Vereh.	Ilfor, Bukarest.	Doljus, Varbitza.	—	krank zugezogen.	Seit 1893.
115	Salonita Milza Kerciu, 45 J., wbl.	Ledig.	Mehedinti, Orevitza.	Mehedinti, Osevitza.	Hier geboren.	—	Seit 1882.
116	Michail Serban, 14 J., männl.	Vereh.	Mehedinti, Vanjullare.	Mehedinti, Vanju Mare.	do.	—	Seit 1892.
117	Nicolai G. Ceaus 32 J., männl.	Ledig.	Mehedinti, Almagel.	Mehedinti, Almagel.	do.	—	Seit 1894.
118	Elisabeta N. Plesu, 20 J., weibl.	Vereh.	Mehedinti, Closani.	Mehedinti, Closani.	do.	—	Seit 1891.
119	Calina Dimitra Cista, 50 J., wbl.	Ledig.	Mehedinti, Obargia.	Mehedinti, Obargia.	do.	—	Seit 1891.

at. schon ärztlich ıandelt worden, ı, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnortoder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
ındelt in der Unisitäts-Hautkl.	Keine Kranken in d. Familie.	Weiss nichts anzugeben.	—	—
ındelt 2 Monate Krankenh. Conoi.	do.	do.	—	—
2 Jahren im Kranbaus Bukarest.	do.	do.	—	—
—	do.	do.	Lepra tuberosa.	Bemittelt.
Krankenhaus zu schani.	do.	do.	do.	Arm.
t behandelt.	do.	do.	do.	—
do.	do.	do.	do.	—
do.	do.	do.	do.	—
—	—	—	—	—
—	—	—	—	—
ındelt i. Kranken-:s Brinkoveneu.	Hatte 2 Brüder die an Lepra gestorben sind.	Wahrscheinlich v. den Brüden angesteckt.	Lepra tuberosa.	Arm.
behandelt ohne olg.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Bemittelt.
ərBehandlung des nkoveasa Hospit.	do.	do.	—	—
ler Univers Hautnik behandelt.	Der Vater an Lepra gestorben.	Von seinem Vater angesteckt.	—	—
ıt behandelt.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	Lepra tuberosa.	Arm.
do.	do.	do.	do.	do.
ɔnate im Kranken-ıs zu Vanju Mare.	do.	do.	do.	do.
—	Vater und Bruder leprakrank.	Angesteckt von Vater und Bruder.	Lepra mixta.	Nicht arm
Behandlung des ankenhauses Baia Arania 1 Woche.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Arm.

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120	Jon Gh. Storkitzous, 15 J., männl.	Ledig.	Mehedinti, Matasaru.	Mehedinti, Matasaru.	Hier geboren.	Krank zugezogen.	Seit 1895.
121	Marina Vutscha, 26 J., weibl.	do.	Mehedinti, Ponoarele.	Mehedinti, Panoarele.	do.	—	Seit 1882.
122	Joana J. Valceanu, 30 J., weibl.	Vereh.	Mehedinti, Baia de Lus.	Mehedinti, Baia de Lus.	do.	—	Seit 1890 (ke Berührung i der russ. Arm
123	Florea Gogau, 45 J., waibl.	Ledig.	Mehedinti, Retezu.	Mehedinti, Retezu.	do.	—	Seit 1874.
124	Naie Atanasesen, 60 J., männl.	Vereh.	Mehedinti, Cioroborem.	Prabova, Oloesti.	Von Ploesti zugezogen.	—	Seit 1894.
125	Calina Dragota, 60 J., weibl.	Witwe	Mehedinti, Colosami.	Mehedinti, Closani.	Hier geboren.	—	Seit 1878 (ke Berührung der russ. Arm
126	Petru Cioba, 59 J., männl.	Vereh.	Mehedinti, Verciorows.	Mehedinti, Verciorova.	do.	—	Seit 1888.
127	Nicolai Cornea, 7 J., männl.	—	Mehedinti, Closani.	Mehedinti, Closani.	do.	—	Seit 1899.
128	Gheorghe J. Ciontes, 30 J., männl.	Ledig.	Mehedinti, Cernetz.	Mehedinti, Cernetz.	do.	—	Seit 1896.
129	Dinca Gogosa, 55 J., männl.	Vereh.	Mehedinti, Gurila Mare.	Mehedinti, Guriba Mare.	do.	—	Seit 1893.
130	Ana N. Cornea 35 J., weibl.	do.	Mehedinti, Closani.	Gor Jin, Pohruia.	Von Pohruia zugezogen.	gesund zugezogen.	Seit 1898.
131	Joana Pantelimon Serafun, 56 J., weibl.	do.	Mehedinti, Najulesti.	Mehedinti, Girova.	Von Najulesti zugezogen.	do.	Seit 1892.
132	Marita Tona Sima, 40 J., weibl.	do.	do.	Mehedinti, Vajulesti.	Hier geboren.	—	Seit 1891.
133	Elisabeta G. Borangin, 27 J., weibl.	do.	Mehedinti, Paroina Marc.	Mehedinti, Fautenele Negre.	Von Fautenele Negre zugezogen.	krank zugezogen.	Seit 20 Jahre
134	Colina Brandeburg, 46 J., weibl.	do.	Mehedinti, Obarjia.	Mehedinti, Obarjia.	Hier geboren.	—	Seit 14 Jahre
135	Ciubalca Constantin, 28 J., männl.	do.	Mehedinti, Povreji.	Mehedinti, Povreji.	do.	—	Seit 1902.
136	Gheorghe Serafin, 18 J., männl.	Ledig.	Mehedinti, Biginlesti.	Mehedinti, Biginlesti.	do.	—	Seit 6 Jahren
137	Anica Godescu, 29 J., weibl.	Vereh.	Mehedinti, Catanele.	Mehedinti, Closani.	Von Comanesti zugezogen.	gesund zugezogen.	Seit 1 Jahr.
138	Constantina Ungureanu, 14 J., weibl.	Ledig.	Mehedinti, Jidoskitza.	Mehedinti, Jidoskitza.	Hier geboren.	—	Seit 8 Monat

…chon ärztlich …elt worden, …ie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
…ndlung des …nhauses zu … 1 Monat.	Vater an Lepra gestorben und Mutter krank.	Wahrscheinlich Ansteckung von den Eltern.	Lepra mixta.	Arm.
Krankenhaus … de Arania.	Mutter und Bruder an Lepra gestorben.	Wahrscheinlich Ansteckung.	Lepra nervosa.	Bemittelt.
idem.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	—
	Mutter, Bruder und 1 Schwester an Lepra gestorben.	Wahrscheinlich Ansteckung.	—	—
in ärztlicher …lung.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	Lepra anaeshetica.	—
…handelt.	do.	do.	Lepra mutilans.	—
im Kranken… … T. Severus.	do.	do.	Lepra mixta.	—
…ehandlung.	Die Mutter krank an Lepra.	Wahrscheinlich d. Ansteckung v. d. Mutter.	—	—
…m Krankenh. …n-Severin.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	—
…r in der Be…ig des Kran…s zu Calafat.	do.	do.	—	—
Krankenhaus … de Arania.	do.	do.	—	—
…Behandlung …nh. Strehaia.	do.	Wahrscheinlich von Joan Limon angesteckt.	—	—
	do.	Vermutet von der Serafin angesteckt zu sein.	Lepra anaeshetica.	—
in ärztlicher …lung.	do.	Weiss nichts anzugeben.	do.	Bemittelt.
…rztliche Be…ig.	do.	do.	—	—
…ir-Lazaret zu …t.	do.	do.	Lepra mutilans (anaesthet.)	Arm.
in ärztlicher …lung.	do.	do.	—	Bemittelt.
…rztliche Be…ig.	do.	do.	—	Nicht bemittelt.
do.	do.	do.	Lepra tuberosa.	Arm.

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139	Maria Vacarescu. 27 J., weibl.	Vereh.	Mehedinti, T. Severin.	Mehedinti, Pere.	Von Pere zugezogen.	Gesund zugezogen.	Seit 5 Jahren.
140	Maria Comanescu. 40 J., weibl.	Ledig.	Musul, Micesti.	Musul, Micesti.	Hier geboren.	—	Gibt an seit (burt krank sein.
141	Branescu Jan. 63 J., männl.	Vereh.	Musul, Cotesti.	Musul, Cotesti.	do.	—	Seit 1892.
142	Florian Poss, 43 J., männl.,	do.	Musul, Campu Lung.	Siebenbürgen.	Zugezogen von Siebenbürgen.	—	Seit 1889.
143	Gheorghe Postelnicu, 35 J., männl.	do.	Musul, Slanik.	Musul. Slanik.	Hier geboren.	—	Seit 1895.
144	Jon Tudose Possa Stau, 18 J., männl.	Ledig.	Musul, Stanesti.	Musul, Stanesti.	do.	—	Seit 1890.
145	Petrica Gleits Dinu 41 J., männl.	do.	Musul, Mihaesti.	Musul, Mihaesti.	do.	—	Seit 1882.
146	Jon Nicolai Badea, 50 J., männl.	Vereh.	Musul, Albesti.	Musul, Albesti.	do.	—	Seit 1883.
147	Nicolai Botoi, 36 J., männl.	Witwer.	Musul, Colibas.	Musul, Colibas.	do.	—	Seit mehreren Jahren.
148	Lutza Tauase Zidaru, 50 J., weibl.	Vereh.	Musul. Micesti.	Musul, Micesti.	do.	—	Seit 1893.
149	Alexandru Badea Maudrutz, 29 J., männlich.	Ledig.	Muscel, Micesti.	Muscel, Bogesti.	Zugezogen v. Bagesti.	Gesund zugezogen.	Seit 1891.
150	Maritza Dumitrache. 24 Jahre, weiblich.	do.	Muscel, Campu Lung.	Muscel, Campu Lung.	Hier geboren.	—	Seit 1895.
151	George Alexe Marin Grigore, 14 J., männlich.	do.	Muscel, Jupinesti.	Muscel. Jupinesti.	do.	—	Seit 1898.
152	Paraschiva Al. M. Grigore. 40 J., weiblich.	Vereh.	do.	do.	do.	—	Seit 1899.
153	Grigore Christesen, 17 J., männlich.	Ledig.	Muscel, Ciuluita.	Muscel, Ciuluita.	do.	—	—
154	Gheorghe Christesen, 8 J., männl.	do.	do.	do.	do.	—	—
155	Maria Zaken, 20 J., weiblich.	do.	Muscel. Draghici.	Muscel, Schitu Golescu.	Von Schitu Golescu zugezogen.	Krank zugezogen.	Seit mehrer. J
156	Oprea Carciumaresen, 46 Jahre, männlich.	Vereh.	Muscel, Topoloveni.	Muscel, Leordeni.	Von Leordeni zugezogen.	Gesund zugezogen.	Seit 1886.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige lepros, welche, und hat Pat. in seinem Wohnorte oder sonstwo einen ähnlichen Kranken, wer, wann derselbe?	[illegible]	Form der Krankheit	[illegible]
Keine ärztliche Behandlung.	Keine Kranken in der Familie	Weiss nichts anzugeben.	Lepra anaesthetica.	Arm.
do.	do.	do.	do.	do.
Krankenhaus zu [illegible] Lung.	do.	do.	do.	do.
[illegible] Krankenhaus.	do.	do.	—	do.
Krankenhaus zu Lung.	do.	do.	Lepra anaesthetica.	do.
Krankenhaus zu [illegible].	do.	do.	do.	do.
Nicht behandelt.	do.	do.	Lepra mixta.	do.
do.	do.	do.	Lepra tuberosa.	do.
[illegible] in ärztlicher Behandlung.	do.	do.	do.	[illegible]
Nicht behandelt.	do.	do.	Lepra mixta.	Arm.
do.	do.	Weiss nichts anzugeben. In [illegible] sind [illegible] Lepra-kranke.	Lepra anaesthetica.	do.
do.	do.	Weiss nichts anzugeben.	Lepra tuberosa.	do.
do.	Vater und Mutter waren [illegible] krank.	Wahrscheinlich [illegible] von den Eltern.	do.	do.
do.	[illegible] Mann war lepros [illegible]	Wahrscheinlich [illegible]	Lepra anaesthetica.	do.
—	—	—	do.	—
—	—	—	do.	—
Nicht behandelt.	Keine Kranken in der Familie	Weiss nichts anzugeben.	Lepra mixta.	Arm.
[illegible] in ärztlicher Behandlung.	do.	do.	Lepra anaesthetica. [illegible] Pat. [illegible] [illegible] auf der [illegible] [illegible]. Die Finger der [illegible] Hand sind [illegible].	—

Nummer	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877– stattgefunden
157	Nicolai Bucur Sanoni, 20 J., männlich.	Ledig.	Muscel, Capu Piscului.	Muscel, Capu Piscului.	Hier geboren.	—	Seit seinem 7.
158	Adriana N. Feraru, 82 J., weiblich.	Witwe.	Muscel, Verwoesti Ringureni.	Muscel, Vervoesti Ringureni.	do.	—	Seit 1900.
159	Lina N. S. Buricel, 30 J., weiblich.	Vereh.	Muscel, Valea Mare.	Muscel, Valea Mare.	do.	—	Seit 7 Jahren.
160	Nicolai N. Visoin, 20 J., männlich.	Ledig.	Muscel, Capu Piscului.	Muscel, Capu Pisculus.	do.	—	Seit 1895.
161	Gheorghe Stanescu, 26 Jahre, männlich.	do.	Muscel, Voinesti.	Muscel, Voinesti.	do.	—	Seit 1900.
162	Nicolai Gaganta, 16 J., männlich.	do.	Muscel, Vladesti.	Muscel, Vladesti.	do.	—	Seit 1902.
163	AronNitaHonboin, 21 J., männlich.	do.	Muscel, Miclosani.	Muscel, Miclosani.	do.	—	Seit 1900.
164	Ileana D. Recea, 18 J., weiblich.	do.	Muscel, Mihaesti.	Muscel, Mihaesti.	do.	—	Seit 1900.
165	Mucenci Pavel Prodee, 26 J., männlich.	do.	Muscel, Corbi.	Muscel, Corbi.	do.	—	Seit 1898.
166	Jon Chiriar, 62 J., männlich.	Vereh.	Muscel, Contesti.	Muscel, Contesti.	do.	—	Seit 1898.
167	Niculai Opres Militari, 43 J., männlich.	do.	Muscel, Valea Popei.	Muscel, Voinesti.	Von Voinesti zugezogen.	Gesund zugezogen.	Seit 1886.
168	Jon Jejea, 20 J., männlich.	Ledig.	Muscel, Stanesti.	Muscel, Stanesti.	Hier geboren.	—	Seit 1902.
169	Stanca Stan, 50 J., weiblich.	do.	Olt, Mihaesti.	Olt, Mihaesti.	do.	—	Seit 1883.
170	Mitra G. Mitran, 53 J., weiblich.	Vereh.	Olt, Dudu.	Olt, Dudu.	do.	—	Seit 1880.
171	Paraschiva Stan Burus, 42 Jahre, weiblich.	do.	Olt, Priseaca.	Olt, Priseaca.	do.	—	Seit 1896.
172	Voica Christea, 30 J., männlich.	Ledig.	Olt, Michaesti de jos.	Olt, Stoicanesti.	Von Stoicanesti zugezogen.	Gesund zugezogen.	Seit längerer krank, keine rührung mit russ. Armee.
173	Tesmeann Ilee. 18 J., männlich.	do.	Olt, Ibanesti.	Ost. Ibanesti.	Hier geboren.	—	Seit 1900.
174	Jon Nica Nistor, 38 J., männlich.	do.	Olt, Milcov.	Olt, Milcow.	do.	—	Seit 22 Jahren
175	Constantin Raducu, 45 J., männl.,	Vereh.	Olt, Serbanesti de Jos.	Ost, Serbanesti de Jos.	do.	—	Seit 1902.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	[illegible] Familienangehörige [illegible]	[illegible]	[illegible]	[illegible]
Keine Behandlung.	Keine Kranken in der Familie.	[illegible]	[illegible]	—
Ist im Krankenhaus zu Campu Lung gewesen.	do.		[illegible]	[illegible]
Nicht behandelt.	[illegible]		[illegible]	do.
do.	do.		[illegible]	do.
do.	do.			do.
do.	do.			do.
do.	do.		[illegible]	[illegible]
do.	Der Vater verstorben.	[illegible]		do.
do.	do.			[illegible]
do.	Keine Kranken in der Familie.			—
Im Krankenhaus [illegible] Lung und [illegible] Bukarest.	Weiss [illegible] einem [illegible]	[illegible]	[illegible]	—
Im Krankenhaus zu Pitesti im J. 1902.	Keine Kranken in der Familie.	•		—
Nicht behandelt.	do.		—	[illegible]
do.	do.		[illegible]	[illegible]
Im Krankenhaus zu Slaten.	Kann nicht angeben, was für eine Krankheit der Vater gehabt [illegible]	—		[illegible]
Im Krankenhaus zu Rosieh.	Keine Kranken in der Familie.	[illegible]	[illegible]	
Nicht behandelt.	do.		—	-
Oefters behandelt.	Der Vater [illegible] dieselbe Krankheit [illegible] haben.	[illegible]	[illegible]	
Nicht behandelt.	Keine Kranken in der Familie.	[illegible]	[illegible]	-

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877– stattgefunden
176	Aughel Jancu, 23 J., männlich.	Vereh.	Prahova, Ploesti.	Macedonia, Ohrida.	Von Craiova zugezogen.	Krank zugezogen.	Seit 1883.
177	Veta Mogosescu, 25 J., weiblich.	Witwe.	do.	Ilfov, Bucarest.	Von Bukarest zugezogen.	Gesund zugezogen.	Seit 1887.
178	Maria Stan Tomes, 58 J., weiblich.	do.	Prahova, Ditesti.	Prahova, Ditesti.	Hier geboren.	—	Seit 1885.
179	Maria Dumitru Buliga, 68 Jahre, weiblich.	—	Prahova, Sinaia.	Transilvauren, Brasov.	Von Brasov zugezogen.	Krank zugezogen.	Seit 1879.
180	Jordache Aldea, 35 J., männlich.	—	Prahova, Aricesti.	Prahora, Aricesti.	Hier geboren.	—	Seit 1877.
181	Gheorghe Dinn, 25 J., männlich.	Ledig.	Prahova, Baiconi.	Prahora, Baicocu.	do.	—	Seit 1897.
182	Safta Tama Constantin, 30 J., weiblich.	Vereh.	Prahova, Fantanele.	Prahora, Ciocani de jos.	Von Ciocani de jos zugezogen.	Gesund zugezogen.	Seit 1892.
183	Stanca Milu Vitej, 64 J., weiblich.	Ledig.	Prahova, Sinaia.	Prahora, Sinaia.	Hier geboren.	—	Seit 1868.
184	Jon Dragoin, 30 J., männlich.	do.	Prahova, Surani.	Prahora, Purani.	do.	—	Seit 1893.
185	Pescaru Jon, 25 J., männlich.	Vereh.	Prahova, Breaza de jos.	Prahora, Breaza de jos.	do.	—	Seit 1898.
186	Stancin Dragomer, 30 J., männlich.	do.	Prahova, Surani.	Prahora, Surani.	do.	—	—
187	Liesandru Savu, 23 J., männlich.	do.	Prahova, Ciojdeni.	Prahova, Ciojdeni.	do.	—	—
188	Coust Serbau, 18 J., männlich.	Ledig.	Prahova, Pacuesti.	Prahova, Pacuesti.	do.	—	—
189	Jon N. Dobrescu, 14 J., männlich.	do.	Prahova, Isvórele.	Prahova, Isvórele.	do.	—	Seit 1898.
190	Mihai Gheorghe, 32 J., männlich.	do.	Prahova, Ghitesti.	Prahova, Glutesti.	do.	—	Seit dem Mili dienst.
191	Gheorghe Potarca, 70 J., männlich.	Witwer.	Prahova, Predeal.	Prahova, Predeal.	do.	—	Seit 1897.
192	Coust Dinn Trocaru, 16 J., männl.	Ledig.	Prahova, Carbunesti.	Prahova, Carbunesti.	do.	—	Seit 1901.
193	Nicolai Filipoeu, 33 J., männlich.	Vereh.	Prahova, Manecui Pamintesti.	Prahova, Maneciu Pamintesti.	do.	—	Seit 1900.
194	Dumitru Nicolaide (J. Ilfov), 28 J., männlich.	do.	(J. Ilfov, Putna), Focsam.	Tulcea, Tulcea.	Von Burgas (Bulgaria) zugezogen.	Krank zugezogen.	Seit 1894.
195	Panait M. Emanoil, 42 J., männl.	do.	Romanati, Caracal.	Türkei, —	Von Türkei zugezogen.	Gesund zugezogen.	Seit 1890.
196	Rada S. Ochia, 64 J., weiblich.	Witwe.	Romanati, Islaz.	Romanati, Jinvarest.	Von Jinvaresti zugezogen.	Krank zugezogen.	Seit 1887.

Ist Pat. schon ärztlich behandelt worden, wann, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
Im Krankenhaus zu Craiove.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	—	Wenig bemittelt.
1887 5 Wochen im Krankenh. z. Ploesti.	do.	do.	—	do.
Vom Kreisarzt.	do.	do.	Lepra mutilans.	Arm.
In Brasco, Campina u. Sinaia.	do.	do.	Lepra anaesthetica.	do.
1881 in Brakoveanu-Krankenhaus zu Bukarest.	Vater gesund, Mutter mögl. leprös gestorb.	do.	Lepra mutilans.	do.
Im Krankenhaus zu Ploesti.	Keine Kranken in der Familie.	do.	Lepra tuberosa.	Mittelm.
Im Krankenhaus zu Mizil.	do.	do.	do. in Gesicht und Extremitäten.	—
—	—	do.	—	—
Nicht behandelt.	Keine Kranken in der Familie.	do.	Lepra tuberosa.	Mittelm.
Oefters in ärztlicher Behandlung.	do.	do.	Lepra mutilans.	do.
—	—	—	—	Arm.
—	—	—	—	do.
—	—	—	—	—
Im Krankenhaus zu Ploesti.	Keine Kranken in der Familie.	Weiss nichts anzugeben.	Lepra tuberosa in Gesicht u. Extremitäten.	Arm.
Wurde vom Militär entlassen. Im Lazarett Ploesti.	do.	do.	Lepra mutilans.	—
Im Krankenhaus zu Valeni.	do.	do.	—	—
do.	do.	do.	Lepra tuberosa.	—
Nicht behandelt.	do.	do.	do.	—
Behandelt in Konstantinopel, Wien u. Bukarest.	do.	do.	Lepra anaesthetica.	Bemittelt
2 mal in Bukarest behandelt.	do.	do.	do.	do.
1894 im Krankenhaus zu Turus Magurel.	do.	do.	—	—

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197	Paua Mitu, 19 J., weiblich.	—	Romanati, Silistaru.	Romanati, Silistaru.	Hier geboren.	—	Keine sichere Angaben.
198	Stefan S. Mazare, 30 J., männlich.	—	Romanati, Urzua.	Romanati, Urzeca.	do.	—	Im Geburtsort biwakierte die russische Arme 1877 bis 1887.
199	Maria D. Haila, 32 J., weiblich.	Verh.	Romanati, Comanca.	Romanati, Comanca.	do.	—	Seit 1883.
200	JonPreolisNicolai, 48 J., männlich.	do.	Romanati, Cosabia.	Romanati, Corabia.	do.	—	Seit 1899.
201	Stefan Mitu Neica, 15 J., männlich.	Ledig.	Romanati, Potelu.	Romanati, Potelu.	do.	—	Seit längerer Zeit.
202	Maudreas Catinca, 36 J., weiblich.	do.	Teuccin, Corbita.	Tennin, Corbita.	do.	—	Keine sichere Angaben.
203	Stau G. Polojau, 13 J., männlich.	do.	Teleorman, Benca.	Teleorman, Benca.	do.	—	Seit 1900.
204	Alexandru G. Pölojau, 11 J., m.	do.	do.	do.	do.	—	Seit 1900.
205	Neagu Rizu Novideme, 50 J., m.	Verh.	Teleorman, Margwe.	Teleorman, Margwe.	do.	—	Seit der Kindheit.
206	Florea GruiaCalin, 12 J., männlich.	Ledig.	Teleorman, Litza.	Teleorman, Litza.	do.	—	Seit 1899.
207	Necu Petrov, 40 J., männlich.	do.	Tulcea, Jurislovska.	Tulcea, Jurislovska.	do.	—	Seit 1898.
208	Vicol Pawlo, 19 J., männlich.	do.	do.	do.	do.	—	Seit 1893.
209	Voseila Sabastin, 18 J., männlich.	do.	do.	do.	do.	—	Seit 1892.
210	Telegie Ignat, 21 J., männlich.	do.	do.	do.	do.	—	Seit 1891.
211	Vabil Silvestris, 19 J., männlich.	do.	do.	do.	do.	—	Seit 1890 (war in Berührung m. d. russ. Armee).
212	Stefanila Th. Zabaria, 40 J., weiblich.	Verh.	do.	do.	do.	—	Keine richtige Angabe.
213	Matrona Mihail, 13 J., weiblich.	Ledig.	Tulcea, Slava Rusesca.	Aus Russland.	In Russland geb.	Ges. zugez.	Seit 1896.
214	Christina Sidor Simion, 23 J., w.	do.	Tulcea, Carasnat.	Tulcea, Carasnat.	Hier geboren.	—	Seit 1883.
215	Calistrat Trofin Zalismen, 23 J., männlich.	do.	do.	do.	do.	—	Seit 1890.
216	Nastasia Larion Terenti, 30 J., w.	Verh.	Tulcea, Jurislovska.	Tulcea, Jurislovska.	do.	—	Seit 1898.
217	Palaska Terescu Coudrad, 13 J., w.	Ledig.	Tulcea, Kara Orman.	Tulcea, Kara Orman.	do.	—	Seit 1896.

. schon ärztlich ıdelt worden, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit aut andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
ɔehandelt.	Keine Kranken in der Familie.	Weiss nichts anzugeb.	—	Arm.
ankenhaus zu al.	do.	do.	Lepra mixta.	Bemittelt.
ɔehandelt.	do.	do.	Lepra mutilans. Es fehlen d. Finger d. Hände und 4 Zehen vom rechten Fuss.	Arm.
;ea-Hospital zu ·est.	do.	do.	—	—
ɔehandelt.	do.	do.	—	—
do.	do.	do.	—	—
ankenhaus zu in.	Seine Mutter ist leprakrank.	Durch Ansteckung.	Lepra tuberosa.	Arm.
do.	do.	do.	Lepra mutilans.	do.
Behandlung.	Keine Kranken in der Familie. Im Dorf noch andere Kranke.	Weiss nichts anzugeb.	Lepra tuberosa.	do.
do.	do.	do.	do.	do.
nkh. Babadag.	do.	do.	do.	do.
do.	do.	do.	do.	do.
Poliklinik zu lag.	do.	do.	do.	do.
ı Krankenhaus badag.	do.	do.	do.	—
Behandlung.	Eine Tante u. Schwest. der Pat. waren leprakrank.	Durch Ansteckung von seinen Verwandten.	do.	—
lelt 1898.	Keine Kranken in der Familie.	Weiss nichts anzugeb.	Lepra mutilans.	—
Behandlung.	do.	do.	—	—
Ambulatorium lag.	do.	do.	—	Wenig bemittelt.
do.	do.	do.	Lepra tuberosa.	—
behandelt.	do.	do.	—	—
n Krankenhaus ılcea.	Ihr Vater hat eine Schwester, die an Lepra gestorben ist.	Wahrscheinlich Ansteckung.	—	—

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877- stattgefunde
218	LubanaGh.Moisen, 28 J., weiblich.	Verh.	Tulcea, Sulnia.	Tulcea, Kara Orman.	Aus Kara Orman zugezogen.	Krank zugezogen.	Seit 1896.
219	Ivan Haralambie, 58 J., männlich.	do.	Tulcea, Tulcea	Russland.	Aus Russland zugez.	Ges. zugez.	Seit 1898.
220	Andres Evdochin (Cutopola), 43 J., männlich.	Ledig.	Tulcea, Slava Rusa.	Tulcea, Jurislovska.	Aus Jurislovska zugezogen.	do.	Seit 1899.
221	Artion Cusoi Silvestren, 26 J., m.	Verh.	Tulcea, Jurislovska.	do.	Hier geboren.	—	Seit 1894.
222	Pelagia Simion, 55 J., weiblich.	do.	Tulcea. Mahmudia.	Russland, Turtova.	Aus Turtova zugez.	Krank zugezogen.	Seit 1898.
223	Ivan Cozin, 40 J., männlich.	do.	do.	Tulcea, Mahmudia.	Hier geboren.	—	Seit 1898.
224	Dementi Absardru, 13 J., männl.	—	Tulcea, Murighiol.	Tulcea, Murighiol.	do.	—	Seit 1899.
225	Warwara Gavul Petrow, 56 J., weibl.	Verh.	do.	do.	do.	—	Seit 1868.
226	Prohor Tanasov, 28 J., männlich.	Ledig.	do.	do.	do.	—	Seit 1882.
227	Nastasia Anesia Dementi, 15 J., w.	do.	do.	Tulcea, Sulina.	Aus Sulina zugezog.	Ges. zugez.	Seit 1898.
228	Maria Jacoveneu, 19 J., weiblich.	do.	do.	do.	do.	do.	Seit 1899.
229	Lupkin Tanase, 36 J., männlich.	do.	do.	Tulcea, Jurislovska.	Aus Jurislovska zugezogen.	do.	Seit 1895.
230	Parfil Tanase Cornescu, 20 J., m.	do.	Tulcea, Caraorman.	Tulcea, Caraorman.	Hier geboren.	—	Seit 1897.
231	Ivan Josef Simionoff, 17 J., männl.	do.	do.	do.	do.	—	Seit 1901.
232	Elena Gerasius Suchor, 61 J., w.	Verh.	Tulcea, Satu Nou.	Tulcea, Sates Nou (Letea).	do.	—	Seit 1895.
233	Leonte Jacob, 32 J., männlich.	do.	Tulcea, Tulcea	Tulcea, Jurislovska.	Aus Jurislovska zugezogen.	Ges. zugez.	Seit 1899.
234	Irima Ivan Nichita, 75 J., weiblich.	Ledig.	Tulcea, Slava Rusa.	Russland.	Aus Russland zugez.	do.	Seit 1898.
235	Irina Lerica Mihailov, 50 J., weibl.	do.	do.	do.	do.	do.	Seit 1899.
236	Aftemia Ahaia Nita, 52 J., weibl.	do.	do.	do.	do.	do.	Seit 1898.
237	Efimia Nichifor, 35 J., weiblich.	do.	Tulcea, Siftovka.	Tulcea, Siftovka.	Hier geboren.	—	Seit 1898.
238	Ivan Petre Minaev, 21 J., männlich.	do.	Tulcea, Slava Rusa.	Tulcea, Slava Rusa.	do.	—	Seit 1900.

t Pat. schon ärztlich behandelt worden, ınn, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
cht behandelt.	Keine Kranken in der Familie.	In Kara Orman gibt es mehrere Leprakranke.	—	—
ı Krankenhaus zu 'ernavoda.	Weiss nichts v. seinen Eltern.	—	Lepra tuberosa.	—
do.	Keine Kranken in der Familie.	Weiss nichts anzugeb.	do.	—
cht behandelt.	do.	do.	do.	—
do.	do.	do.	do.	—
ivatärztliche Beandlung.	do.	do.	Lepra anaesthetica.	—
cht behandelt.	do.	do.	Lepra tuberosa.	Arm.
do.	do.	do.	Lepra mutilans. Die Endphalangen vom Daumen d. r. Hand abgefallen.	do.
do.	do.	do.	Lepra mutilans.	do.
do.	Ihre Mutter ist an Lepra gestorben.	do.	Lepra tuberosa im Gesicht, Nase und r. Arm.	do.
do.	Keine Kranken in der Familie.	do.	Lepra tuberosa, Gesicht, Nase u. Gambe.	do.
do.	do.	do.	Lepra tuberosa, Gesicht, Stirn, Nase, auf der Unterlippe ein Geschwür.	—
ı Krankenhaus zu 'ulcea.	do.	do.	Lepra tuberosa.	—
cht behandelt.	do.	do.	do.	—
do.	do.	do.	Lepra tuberosa, Gesicht, Hände und Füsse m. Geschwür.	—
00 im Krankenhaus u Tulcea.	do.	do.	Lepra anaesthetica.	—
cht behandelt.	do.	do.	—	Arm.
do.	do.	do.	—	do.
do.	do.	do.	—	do.
do.	do.	do.	—	do.
do.	do.	do.	—	Bemittel

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877– stattgefunden
239	Cubina M. Lava, 32 J., weiblich.	Verh.	Tulcea, Murighiol.	Tulcea, Murighiol.	Hier geboren.	—	Seit 1892.
240	Simion Pavel, 70 J., männlich.	do.	Tulcea, Isaecea.	Tulcea, Isaecea.	do.	—	Seit 1892.
241	IgnatLebder, 45 J., männlich.	Ledig.	Tulcea, Jurislovska.	Tulcea, Jurislovska.	do.	—	Seit 1901.
242	Arion Irimia Tanase, 11 J., m.	do.	Tulcea, Murighiol.	Tulcea, Murighiol.	do	—	Seit 1903.
243	Lucretia Tulcan, 30 J., weiblich.	do.	Tutova, Costesti.	Transilvania.	Aus Transilvanien zugezog.	Krank zugezogen.	Seit 1890.
244	Amia al Cherebalau, 32 J., weibl.	do.	R. Valcea, R. Valcea.	R. Valcea, R. Valcea.	Hier geboren.	—	Seit 1889.
245	Maria Gh. Calota, 37 J., weiblich.	Verh.	R. Valcea, Fometesh.	R. Valcea, Fometesh.	do.	—	Seit 1894.
246	Pavel Bouguri, 40 J., männlich.	Verh.	R. Valcea, Roman.	R. Valcea, Roman.	do.	—	Seit 1882.
247	Zamfis Nicolai, 60 J., männlich.	Wittw.	R. Valcea, Madulars.	R. Valcea, Madulars.	do.	—	Seit 1889.
248	Demitris Bogoranca, 34 J., m.	Ledig.	R. Valcea, Ramesti.	R. Valcea, Ramesti.	do.	—	Seit 1896.
249	Elena C. Carjoia, 25 J., weiblich.	Verh.	R. Valcea. Govora.	R. Valcea, Govora.	do.	—	Seit 1894.
250	Maria Coust J. Mihas, 28 J., w.	Geschied.	do.	do.	do.	—	Seit 1893.
251	Nicolai G. Stoccia, 25 J., männlich.	Ledig.	do.	do.	do.	—	Seit 1895.
252	Rosa Florea D. Aughel, 8 Mon., weiblich.	—	do.	do.	do.	—	Seit 1—4 Cu
253	Maria Poscescu, 20 J., männlich.	Ledig.	R. Valcea, Cermegesti.	R. Valcea, Cermegesti.	do.	—	—
254	Maria Marin Simeon, 40 J., w.	Verh.	R. Valcea, Cacova.	R. Valcea, Cheia.	Von Cheia zugezog.	Krank zugezogen.	Seit 1897.
255	Gheorghe Rada Petea, männlich.	Ledig.	R. Valcea, Otesani.	R. Valcea, Otesani.	Hier geboren.	—	Seit 1897.
256	Constantin Petea, 18 J., männlich.	do.	do.	do.	do.	—	Seit 1896.
257	Hinca Gr. Jonescu, 22 J., weiblich.	Verh.	R. Valcea, Bodesti.	R. Valcea, Bodesti.	do.	—	Seit 1897.
258	Constantin Botca, männlich.	do.	R. Valcea, Folesti de Sus.	R. Valcea, Folesti de Sus.	do.	—	Seit 1895.
259	Joua G. Moritoin, 41 J., weiblich.	do.	R. Valcea, Alumo.	R. Valcea, Alumo.	do	—	Seit 1899.
260	Marin Areft, 22 J., männlich.	do.	R. Valcea, Govora.	R. Valcea, Govora.	do.	—	Seit 1900.
261	Hie Naileanu, 36 J., männlich.	do.	R. Valcea, Zabreus.	R. Valcea, Zabreni.	do.	—	Seit 1900.

Pat. schon ärztlich ehandelt worden, nn, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, sah Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
ht behandelt.	Keine Kranken in der Familie.	Weiss nichts anzugeb.	—	Arm.
do.	do.	do.	—	do.
do.	do.	do.	—	—
Krankenhaus zu ıbadag.	do.	do.	—	Arm.
Brankoveanuhosp. Bukarest 6 Mon.	do.	do.	Lepra tuberosa.	do.
do.	do.	do.	—	do.
Krankenhaus zu ›rez.	do.	do.	Lepra tuberosa.	do.
Krankenh. Horez.	do.	do.	—	—
do.	do.	do.	—	—
ht behandelt.	do.	do.	Lepra mutilans.	—
do.	Keine Kranken in der Familie. Im Dorf noch andere Kranke.	do.	Lepra tuberosa.	—
do.	do.	do.	do.	—
Krankenhaus zu ›rez 1898.	do.	do.	do.	—
ht behandelt.	do.	do.	Lepra anaesthetica.	—
—	—	—	—	—
Krankenhaus zu Valcea.	Keine Kranken in der Familie. Im Dorf noch andere Kranke.	Weiss nichts anzugeb.	—	Wenig be mittelt.
ht behandelt.	do.	do.	—	Arm.
do.	do.	do.	—	do.
Krankenhaus zu ›rez.	do.	do.	—	do.
ht behandelt.	Hat 2 Vettern leprakrank.	Wahrscheinlich Ansteckung, seine Frau u. Kinder sind ges.	Lepra mutilans.	do.
do.	Keine Kranken in der Familie.	Im Dorfe waren noch andere Leprakranke.	Lepra tuberosa.	do.
ärztlich. priv. Bendlung.	do.	Weiss nichts anzugeb.	—	do.
ne Behandlung.	do.	do.	—	do.

Nummer.	Namen, Alter, Geschlecht.	Verehelicht oder ledig.	Wohnort (Bezirk, Gemeinde).	Geburtsort (Bezirk, Gemeinde).	Ist Pat. in seinem jetzigen Wohnort geboren oder von einem anderen Ort zugewandert? Woher?	War Pat. bereits erkrankt als er sich in diesem Orte niederliess?	Seit wann ist P krank, wie ist d selbe erkrankt, irgend ein Verk mit den Russ während de Krieges 1877– stattgefunde
262	Constantin Bozac, 16 J., männlich.	Ledig.	R. Valcea, Stoenesti.	R. Valcea, Stoenesti.	Hier geboren.	—	Seit 1899.
263	FloreaStanPatono 45 J., weiblich.	Verh.	R. Valcea, Calimanesti.	R. Valcea, Calimanesti.	do.	—	Seit 1892.
264	Lina A. Popa, 19 J., weiblich.	Ledig.	R. Valcea, Calimanesti Gura Vau.	R. Valcea, Calimanesti Gura Vau.	do.	—	Seit 1896.
265	Rada G. Macedon, 22 J., weiblich.	do.	R. Valcea, Madulan.	R. Valcea, Madulari.	do.	—	Seit längerer krank.
266	Nicolai Ilie Magureanu, 23 J., m.	do.	R. Valcea, Ulmet.	R. Valcea, Ulmet.	do.	—	Seit 1892.
267	Lisabeta P. Diaconu, 46 J., w.	do.	R. Valcea, Ursi.	R. Valcea, Ursi.	do.	—	Seit mehr. Jah
268	Maria Preda Cudalbu, 36 J., w.	do.	R. Valcea, Govora.	R. Valcea, Govora.	do.	—	Seit 1895.
269	Maria G. Florea, 28 J., weiblich.	Verh.	R. Valcea, Bogdanesti.	R. Valcea, Bogdanesti.	—	—	Seit 1895.
270	TudoraChiresBurcea, 45 J., m.	—	Vlasca, Popesti.	Vlasca, Draganesti.	VonDraganesti zugezogen.	Gesund zugezogen.	Seit 1886. W d. Krieges h er einen Ru in Quartier.
271	Jon Bibita, 22 J., männlich.	Verh.	Vlasca, Balanae.	Vlasca, Balanaie Turbatis.	Hier geboren.	—	Seit 1900.
272	Vasilca Stancu Palmus, 55 J., w.	do.	Vlasca, Arsache.	Vlasca, Arsachs Balari	do.	—	Seit 1882.
273	Florea Jon, 27 J., männlich.	—	Vlasca, Pietres.	—	—	—	—
274	Sore Jipa, 23 J., männlich.	Ledig.	Prahou, Aricesti.	—	—	—	Seit 1902.

…Pat. schon ärztlich …handelt worden, …n, wie lange, wo?	Litten d. Eltern d. Pat. an Lepra, sind sonstige Familienangehörige leprös, welche, hat Pat. in seinem Wohnort oder sonstwo einen ähnlich Erkrankten, wie hiess derselbe?	Welche ist die Ansicht des Pat. über das Entstehen der Krankheit? Hat er selbst die Krankheit auf andere übertragen?	Form der Krankheit.	Vermögensverhältnisse.
…e Behandlung.	Keine Kranken in der Familie.	Von einer an Lepra verstorb. Freundin bekomm. zu haben.	—	—
do.	do.	Weiss nichts anzugeb.	—	—
do.	do.	do.	Lepra mutilans. Geschwüre im Pharynx und Unterschenkel.	Arm.
do.	do.	do.	Lepra tuberosa.	do.
…ers in Behandlg.	do.	do.	do.	do.
…t behandelt.	do.	do.	Lepra mutilans.	do.
do.	do.	do.	—	—
Krankenhaus zu Valcea.	do.	do.	—	—
Krankenh. Coltza …karest.	do.	do.	Lepra tuberosa.	Bemittelt.
milit. Lazarett zu …karest.	do.	do.	—	do.
Krankenhaus zu …ingin.	Keine Kranken in der Familie, seine Kinder sind gesund.	—	—	—
—	—	—	—	—
—	—	—	Lepra maculosa.	—

Russland.

Bericht

von

Prof. **O. v. Petersen** in St. Petersburg.

In dem I. Bande der „Mitteilungen und Verhandlungen der internationalen wissenschaftlichen Lepra-Konferenz zu Berlin im Oktober 1897“ (S. 209—232) habe ich über die Verbreitung der Lepra in Russland in den Jahren 1895—97, auf Grund der mir damals vorliegenden 1200 Meldebogen berichtet, sowie kurz den Gang der Entwicklung der Leprafrage in Russland in der 2. Hälfte des XIX. Jahrhunderts dargelegt.

Seitdem sind 7 Jahre verflossen, in denen eifrig weitergearbeitet worden, um die Ausbreitung der Lepra zu bekämpfen und die vorhandenen Leprösen zu versorgen.

Die Zahl der Leproserien ist vermehrt worden, sowohl von Seiten der Lepra-Vereine, wie auch besonders durch die materielle Hilfe der Staats-Regierung, welche sowohl die vorhandenen Lepra-Vereine unterstützte als auch selbst die Initiative ergriff zum Bau von neuen Asylen, wobei die Resultate der I. internationalen Konferenz nicht ohne Einfluss geblieben sind.

Hatte doch die Arbeit Kirchner's klar dargetan, dass auf die Dauer die privaten Gesellschaften nicht der materiellen Seite der Aufgabe gewachsen sein dürften, und dass schliesslich die Bekämpfung infektiöser Krankheiten die Pflicht der Staats-Regierungen sein müsse. Diese Anschauungen sind durch die Erfahrungen in Russland in den letzten Jahren vollkommen bestätigt. Mit dem Wachsen der Anzahl zu versorgender Lepröser konnten die Vereine ihre Aufgabe nur schwer lösen und mussten sich mit der Bitte um Unterstützungen an die Regierung wenden, die nach Möglichkeit geholfen, vor Allem wohl dank dem Wohlwollen, welches der Geheimrat Dr. L. Ragosin (gegenwärtig Präsident des Medizinalrates) der Angelegenheit entgegenbrachte.

Doch wurde die Leprafrage nunmehr auch von Administrativpersonen angeregt, so von dem General-Gouverneur des Amur-Gebietes, sowie vom Gouverneur von Bessarabien, während die Gouverneure der Ostsee-Gouvernements ihren Vereinen warme Unterstützung boten,

ebenso wie auch namentlich die Livländische Ritterschaft, die es übernommen hat, für jeden in einem Asyl Livlands untergebrachten Leprösen das Kostgeld zu zahlen, d. h. 120 R. (= 259 Mark), also 18—20 000 R. jährlich.

Die Registrierung der Leprösen wird fortgesetzt, doch leidet sie unter einer gewissen Unregelmässigkeit der Einsendung der Meldebogen (die jedoch im Ganzen gut ausgefüllt werden) und deren Schema sich bewährt hat. Am schwierigsten ist es noch, die Zahl der jährlichen Todesfälle unter den Leprösen festzustellen. Selbst in den Berichten der Lepra-Asyle wird die Todesursache meist nicht angeführt. Da es das erste Mal ist, dass eine solche allgemeine Meldepflicht in Russland zur Durchführung kommt, sind derartige Defekte nur zu leicht begreiflich und werden sich allmälig schon vermindern lassen. Im Ganzen sind jetzt über 3000 Meldebogen seit dem Mai 1895 eingelaufen. Sie werden im Medizinal-Departement (von Dr. Grebentschikow und mir) durchgesehen, die Duplikate - ausgeschieden und nach ihrer Bearbeitung alphabetisch geordnet aufbewahrt, um die Duplikate der neu einlaufenden Bogenberichte herausfinden zu können.

Eine eingehende Bearbeitung des gesamten Materials behalten wir uns für das nächste Jahr vor, wo das erste Dezennium der Registrierung abschliesst, für den vorliegenden Bericht habe ich nur die Meldebogen der letzten 3 Jahre (1901—03), im Ganzen 864 Fälle von Lepra betreffend, gewählt, um zu zeigen, wie die Verhältnisse gegenwärtig stehen, im Vergleich zu 1895—97.

Natürlich geben diese Zahlen keinen vollkommenen Ueberblick über die Anzahl der gegenwärtig wirklich vorhandenen Leprösen in Russland, die sich noch nicht sicher feststellen lässt, solange die Meldungen noch an vielen Fehlerquellen leiden und wir namentlich nicht wissen, wieviel Lepröse jährlich sterben.

Wenn wir nun aber auch die Zahl der Leprösen nicht genau kennen, so bietet uns das Material der Meldebogen ein reiches und interessantes Material, aus dem sich doch einige Schlüsse über den Wert und das Zweckentsprechende der bisher ergriffenen Massnahmen ziehen lassen, namentlich wenn wir die Anzahl der jährlich neu registrierten frischen Fälle in Betracht ziehen. Natürlich muss die Registrierung wie bisher fortgesetzt werden und muss namentlich von Zeit zu Zeit durch Zirkulare des Medizinal-Departements auf die sich einschleichenden Fehler aufmerksam gemacht werden, sowie dafür gesorgt werden, dass wirklich aus allen Gegenden die Meldebogen an die Zentralstelle gelangen, und nicht, wie in den letzten Jahren, ein Teil derselben, aus denjenigen Gebieten, die dem Kriegs-Ministerium unterstellt, an die Ober-Medizinal-Verwaltung des letzteren gelangen. Ein anderes Hindernis, die noch lange nicht genügende Versorgung der Bevölkerung mit Aerzten, sodass ein Teil der Land-Bevölkerung noch fast ohne ärztliche Hilfe bleibt, wird freilich erst nach einer Reihe von Jahren wegzuschaffen sein.

Nach den bisherigen Erfahrungen, wie wir dieses ja auch schon aus den offiziellen norwegischen Berichten ersehen, können wir allen Ländern nicht warm genug die Einführung der allgemeinen Meldepflicht für Lepröse empfehlen, als Grundlage aller zu

ergreifenden Massregeln. Meist wird sie ja viel leichter durchzuführen sein, als in Russland mit seinen riesigen Entfernungen und ungenügenden Anzahl der Aerzte auf dem Lande.

Bezüglich der Leproserien können wir zum ersten Male ausführlichere Daten geben, die jedoch auch noch nicht vollkommen sind; doch hoffe ich, dass sie nach weiteren 5 Jahren lehrreiches Material zum Vergleichen bieten werden.

Bezüglich der Massregeln zur Bekämpfung der Lepra ausser der Einrichtung von Leproserien hat Russland in den letzten Jahren ja auch schon Manches getan, doch bleibt noch die schwierige Frage offen, wie man die Leprösen in die Asyle bringt, ohne zu Zwangsmassregeln zu greifen, die durchaus nach Möglichkeit zu vermeiden sind, da sie nur das Gegenteil bewirken können, d. h. die Leprösen sich verstecken werden.

Bezüglich dieser Frage ist von Seiten der „Livländischen Gesellschaft zur Bekämpfung der Lepra" eine Massregel vorgeschlagen, die sehr praktisch erscheint, nämlich die Anstellung eines speziellen Lepraarztes, dessen Aufgabe die systematische Ueberwachung der ausserhalb der Leproserien sich aufhaltenden Leprösen ist. Er müsste dieselben von Zeit zu Zeit aufsuchen, ihre Angehörigen untersuchen und sie zum Eintritt in die Leproserien bewegen. Bisher fehlen jedoch der Gesellschaft zur Anstellung eines solchen Arztes die Mittel. Etwas Aehnliches jedoch hat bereits seit längerer Zeit die Stadt Riga eingerichtet, wo ein Beamter eine Liste sämtlicher nicht ins Asyl gelangter Leprösen der Stadt zu führen hat mit Notierung jeden Wohnungswechsels. Zu diesem Zwecke sucht er die Leprösen periodisch in ihren Wohnungen auf und überredet sie ebenfalls zum Eintritt ins Asyl.

In Estland hat sich eine Rundreise des Arztes des Leprasyls Kuda sehr bewährt, indem er eine Anzahl neuer Fälle entdeckt und dem Asyl zur Aufnahme zugesandt hat.

Ein wesentlicher Faktor des Kampfes mit der Lepra ist auch die Ausbreitung der Kenntnis der Lepra unter den Aerzten, welche ebenfalls in den letzten 7 Jahren Fortschritte gemacht hat, wie wir weiter sehen werden, und sind auf den russischen Aerztekongressen (1899 in Kasan und 1901 in Moskau) verschiedene Lepravorträge gehalten und diskutiert worden; in Kasan war die Lepra sogar das Thema eines Vortrages (Prof. Dr. Dehio) auf einer allgemeinen Versammlung.

In dem Nachfolgenden habe ich mich an das von mir vorgeschlagene Programm gehalten, jedoch die Statistik der Asyle im zweiten Teil der Arbeit gegeben, da die Zahlen ja schon in der Meldebogen-Statistik enthalten sind.

I. Die Verbreitung der Lepra in Russland in den Jahren 1901—1903.

(Nach den bei dem Medizinal-Departement des Ministerium des Innern eingelaufenen Meldebogen.)

Wie bereits erwähnt, waren in den 3 Jahren im ganzen 890 Meldebogen eingesandt, doch mussten davon 25 als Duplikate ausgeschieden werden, und aus 1 Meldebogen konnte man deutlich feststellen, dass

es sich nicht um einen Leprösen handelte; somit verblieben zur statistischen Verwertung 864. (Es ist jedoch möglich, dass auch hier noch einzelne Fälle bereits in früheren Jahren registriert worden, jedenfalls kann die Fehlerquelle nur eine geringe sein; ich führe dieses nur aus Vorsicht an, da ich nicht die Möglichkeit hatte, alle Meldebogen 1895 bis 1900 wieder durchzusehen.)

Es wurden Lepröse gemeldet:

1901	374,	darunter	227 Männer,	147 Weiber
1902	219	„	126 „	93 „
1903	271	„	159 „	112 „
	864		572 Männer,	352 Weiber.

Diese Zahl bezüglich der verschiedenen Geschlechter hat sich im Vergleich zu den früheren pro 1895—97 (633 Männer und 567 Weiber) wohl verschoben, jedoch nicht wesentlich, und lässt sich daraus kein Schluss ziehen, da die Registrierung noch lange nicht vollkommen ist und wohl noch eine nicht geringe Anzahl Lepröser unregistriert bleiben.

a) Der Form der Lepra nach ergibt sich:

	1901—03			1895—97		
		M.	W.		M.	W.
Lepra nodosa . . .	739	455	284	783	438	345
Lepra maculo-nervosa	125	57	68	409	191	218
	864	512	352	1192	629	563

In meinen Bericht 1897 für die internationale Lepraconferenz hatte ich noch eine 3. Kategorie — Lepra mixta — aufgenommen, da es sich jedoch stets um eine Lepra maculo-nervosa handelt, welche in die Lepra nodosa übergegangen, so habe ich die Fälle von Lepra mixta nunmehr der Lepra maculo-nervosa zugezählt. Beiläufig sei erwähnt, dass die Benennung Lepra anaesthetica aus bereits 1897 in meinem Bericht angeführten Gründen nicht akzeptiert ist.

Die im Vergleich zu 1897 kleiner gewordene Anzahl der Fälle von Lepra maculo-nervosa erklärt sich vielleicht dadurch, dass die Leprafälle in denjenigen Gegenden, wo Asyle bestehen, bereits viel früher diagnostiziert worden sind und zwar in einem Stadium, wo rote anästhetische Flecke bestehen, von denen man noch nicht weiss, zu welcher Form diese Initialerscheinungen führen werden, und haben die betreffenden Aerzte auf den Meldebogen die Diagnose Lepra maculo-nervosa notiert. Derartige Fälle von Frühdiagnose finden sich in den 3 Jahren 1901—1903 im ganzen 24.

Tabelle I. (Die Fälle nach Form und Geschlecht geordnet.)

	Lepra maculo-nervosa.			Lepra nodosa.			Im ganzen	
	M.	W.	Sa.	M.	W.	Sa.	M.	W.
1901	24	40	64	203	107	310	227	147
1902	14	12	26	112	71	193	126	93
1903	19	16	35	140	96	236	159	112

b) Die Verbreitung der Lepra nach Gouvernements verteilt (Tabelle II).

Wie man ersieht, sind aus 44 Gouvernements und Gebieten Meldebogen eingelaufen, während aus 8, welche bereits 1897 Lepröse gemeldet, weitere Berichte fehlen, teils weil sie der Militär-Verwaltung unterstellt und dieselbe die Meldebogen dem Ministerium des Innern nicht zugesandt, weil sie selbst mit der Einrichtung von Lepraasylen beschäftigt, teils wohl, weil in den betreffenden Gouvernements, wie Witebsk, Rjäsan, Wologda, keine Fälle weiter beobachtet worden waren. Aus dem Gouvernement Jrkutzk ist wohl ein Verzeichnis von Leprösen eingesandt worden, aber da keine Meldebogen beigelegt sind, so lässt es sich nicht verwerten. Ueberhaupt wird wohl noch einige Zeit vergehen, bis vollständig genaue Verzeichnisse der Leprösen Russlands vorhanden sein werden, da noch mancher Mangel zu verzeichnen ist, so namentlich die, wie schon erwähnt, regelmässige Anzeige der Gestorbenen, die, wie wir aus den Berichten einzelner Leproserien ersehen, zeitweilig nicht gering ist. In den Livländischen Leproserien starben 1897—1901, d. h. in 5 Jahren, 100 Lepröse, in der Kolonie Kru-

Tabelle II.

Gouvernement	1901	1902	1903	1901—3	1895—97	Gouvernement	1901	1902	1903	1901—3	1895—77
Astrachan	5	19	51	75	77	Moskau	2	1	4	7	2
Archangel	—	3	—	3	—	Tula	—	1	1	2	—
Kowno	2	5	—	7	2						
Lublin	1	—	—	1	—	Kaukasus: 157					
Kiew	—	1	—	1	—	Kuban-Gebiet	69	29	27	125	119
Podolien	1	—	—	1	3	Terek-Gebiet	8	4	4	16	51
Mohilew	—	1	—	1	—	Eriwan	5	1	—	6	31
Livland	134	43	54	231	338	Tiflis	2	1	5	8	3
Kurland	21	14	23	58	134	Elisabetpol	—	—	2	2	—
Estland	40	26	12	78	45						
Woronesch	1	1	—	2	1	Sibirien:					
Jekatrinoslaw	6	2	4	12	3	Tomsk	3	—	1	4	—
Kasan	—	—	—	—	—	Irkutsk	4	8	8	20	11
Kaluga	1	4	1	6	—	Ufer-Gebiet	41	13	10	64	33
Kursk	—	1	—	1	4	Ural-Gebiet	—	—	26	26	8
Nishni-Nowgorod	1	1	1	3	—	Jakutsk	?	?	?	?	27
Orel	—	—	1	1	—	Transkaspien	—	2	—	2	7
Poltava	—	2	—	2	1		374	219	271	864	
Pskow	1	2	4	7	5						
Ssamara	3	—	—	3	—	Bessarabien	—	—	—	—	1
St. Petersburg	9	3	7	19	47	Witebsk	—	—	—	—	1
Ssaratow	2	3	3	8	4	Wologda	—	—	—	—	1
Simbirsk	—	—	3	3	—	Rjäsan	—	—	—	—	1
Smolensk	—	1	—	1	4	Jaroslaw	—	—	—	—	1
Taurien	6	5	2	13	15	Kars-Gebiet	—	—	—	—	23
Stawropol	1	4	12	17	10	Baku	—	—	—	—	13
Twer	—	4	—	4	—	Schwarzmeer-Gebiet	—	—	—	—	1
Charkow	4	8	2	14	6	Syr. Darja-Gebiet*)	—	—	—	—	39
Cherson	2	5	2	9	12	Samarkand*)	—	—	—	—	21
Pensa	—	1	—	1	1	Ferghana*)	—	—	—	—	10
Don-Gebiet	—	—	1	1*)	84						1200

*) Es fehlen die Berichte, da sie der Militär-Verwaltung eingesandt.

tija Rutschji in 9 Jahren 43 Leprösc, in dem Astrachanschen Asyl 1901—1903, in 3 Jahren, 30 Leprösc.

Aus Tabelle II ergibt sich, dass in folgenden 13 Gouvernements die Lepra beachtenswerte Ausbreitung gefunden hat: Livland, Kurland, Estland, Astrachan, Jekatrinoslaw, St. Petersburg, Cherson, Kuban-Gebiet, Terek-Gebiet, Jrkutsk, Ufer-Gebiet (Ost-Sibiren), Don-Gebiet, sowie Turkestan.

In den 3 Ostseeprovinzen (Liv-, Kur- und Estland) ist die erfreuliche Tatsache zu bemerken, dass, wohl infolge der Einrichtung der Lepraasyle, sich eine Abnahme der Erkrankungen bemerkbar zu machen beginnt.

Während 1895—97 im ganzen **517** Fälle gemeldet wurden für 2 Jahre, sind 1901—03 — also für 3 Jahre — nur **367** gemeldet und hat sich die Anzahl der frischen (relativ erst seit kurzem) Erkrankten vermehrt. Am deutlichsten macht sich die Abnahme der neuen Erkrankungen im Gouvernement Estland bemerkbar.

In den Gouvernements Astrachan und im Kuban-Gebiet ist noch keine Abnahme deutlich, doch bestehen die Asyle dazu auch noch zu kurze Zeit und ist die Anzahl der Betten noch eine zu geringe.

c) Das Verhältnis der beiden Formen der Lepra scheint je nach den Gegenden ein verschiedenes zu sein, wie es sich namentlich aus einem Vergleich der Berichte aus Norwegen und aus Indien zeigt, doch ist diese Frage noch keineswegs entschieden.

Unsere Zahlen sind in dieser Beziehung natürlich noch viel zu gering, um irgendwelche Schlüsse zu ziehen, wir geben sie daher nur, um Material für zukünftige Verwertung zu bieten (Tabelle III).

Tabelle III.

Die Formen der Lepra in den verschiedenen Gegenden.

		L. nod.	L. mac.-nerv.	
1. Livland	1901	88	46	(männl. 20, weibl. 26),
	1902	36	7	(„ 4, „ 3),
	1903	40	14	(„ 7, „ 7),
		164	**67**	(männl. 31, weibl. 36).
2. Kurland	1901	18	3	
	1902	12	2	
	1903	21	2	
		51	**7**	(männl. 5, weibl. 2).
3. Estland	1901	20	20	(„ 11, „ 9),
	1902	15	11	(„ 3, „ 8),
	1903	9	3	(„ 2, „ 1),
		44	**34**	(männl. 16, weibl. 18).

Im ganzen in den 3 Gouvernements zusammen:

L. nodosa 259
L. mac.-nerv. 108 (männl. 52, weibl. 55).

		L. nodosa	L. mac.-nerv.
4. Kuban-Gebiet	1901	65	4
	1902	29	0
	1903	26	1
		120	**5**
5. Ufer-Gebiet	1901	40	1
	1902	13	0
	1903	9	1
		62	**2**
6. Astrachan	1901	4	1
	1902	13	1
	1903	46	5
		63	**7**

Nur soviel lässt sich auch jetzt schon sagen, dass, je besser die Aerzte in einer Gegend mit den Symptomen der Lepra bekannt sind, um so früher wird die Diagnose gestellt, namentlich auch der Lepra maculo-nervosa. In Gegenden, wo die Anzahl der Aerzte gering ist und dieselben mit den Frühsymptomen der Lepra wenig bekannt sind, kommt auch die Diagnose Lepra maculo-nervosa nur selten vor.

Das Geschlecht scheint keine besondere Rolle bei den verschiedenen Formen der Lepra zu spielen (in Livland kamen auf 31 Männer mit Lepra maculo-nervosa 36 Weiber, in Estland auf 16 Männer 17 Weiber), wohl aber, wie wir weiter sehen werden, scheint das Alter der Patienten einen Einfluss zu haben.

Tabelle IV.

d) Das Alter der Leprösen.

Bei der Meldung der Kranken befanden sich im Alter

	1901—03	1895—97	Summa
bis 10 Jahre	15	9	24
10—20 „	101	134	135
20—30 „	186	225	411
30—40 „	147	249	396
40—50 „	150	196	346
50—60 „	147	155	302
60—70 „	77	145	222
über 70 „	41	59	100
	864	1072	1936

Aus Tabelle V ersieht man deutlich, dass die Lepra maculo-nervosa im höheren Alter häufiger beobachtet wurde als die Lepra nodosa, namentlich bezieht sich dieses auf das Alter über 70 Jahre.

Von 739 Patienten mit Lepra nodosa waren nur 19 über 70 Jahre, dagegen von nur 125 Patienten mit Lepra maculo-nervosa 22.

Dasselbe konnte ich bereits in der 1897 zusammengestellten

Tabelle V.

Nach den Formen der Lepra ergibt sich folgendes pro 1901—03:

	L. nodosa	L. mac.-nerv.
bis 10 Jahre	12	3
11—15 „	20	3
16—20 „	65	7
21—25 „	83	6
26—30 „	87	10
31—40 „	127	20
41—50 „	130	20
51—60 „	128	19
61—70 „	62	15
über 70 „	19	22
	739	125

Tabelle finden, von 783 Patienten mit L. nodosa waren 20 über 70 Jahre, von 317 Patienten mit L. maculo-nervosa 39 über 70 Jahre alt. Es wäre höchst interessant, wenn diese Beobachtung auch von anderer Seite Bestätigung fände.

Bezüglich der Leprösen im Alter bis zu 10 Jahren ist noch hinzuzufügen, dass **der jüngste Patient $1^1/_2$ Jahr** alt war, 1—7 Jahre, 4—8 Jahre, 2—9 Jahre, 7—10 Jahre alt.

Von den über 70 Jahre alten Leprösen waren 71 Jahr 2, 72 5, 73 3, 74 und 75 je 1 und 80 Jahr 2. Bei diesen „alten Herren und Frauen" dürfte wohl kaum mehr die Frage der Heredität der Lepra in Betracht kommen.

e) **Die Dauer der Krankheit** (bis zur Meldung).

Tabelle VI.

Dauer	1901		1902		1903		1901—1903		Summa
	Lepra nod.	Lepra mac.	Lepra nod.	Lepra mac.	Lepra nod.	Lepra mac.	Lepra nod.	L. mac. nerv.	
Bis zu 2 Jahren	69	11	43	8	58	7	170	26	196
2—3 „	30	5	35	2	41	2	106	9	115
3—4 „	40	7	36	3	36	1	112	11	123
4—5 „	29	3	13	2	21	—	63	5	68
5—6 „	25	1	15	1	15	1	55	3	58
6—7 „	12	4	9	3	12	2	33	9	42
7—8 „	11	1	2	1	9	1	22	3	25
8—9 „	17	3	7	1	10	4	28	8	36
9—10 „	7	5	5	—	3	—	15	5	20
10—15 „	13	8	9	2	19	4	41	14	55
15—20 „	4	10	3	3	1	3	8	16	24
über 20 „	—	7	1	1	—	—	1	8	9
unbekannt	—	—	—	—	—	—	85	8	93

Von ganz besonderem Interesse ist die aus dieser Tabelle sich ergebende Tatsache, dass die Frühdiagnose in Russland bedeutende

Fortschritte gemacht hat. Fast der 4. Teil der Fälle ist innerhalb der ersten 2 Jahre diagnostiziert worden, mehr als $^1/_3$ aller Fälle in den ersten 3 Jahren des Bestehens.

Am deutlichsten geht dieses aus einem Vergleich mit den Tabellen meines Berichtes pro 1895—97 hervor. Damals betrug von 1099 Fällen die Dauer des Leidens weniger als 2 Jahre bei 92 Patienten und weniger als 3 Jahre bei 175, während nach dem Bericht pro 1901—03 311 Patienten von 764 weniger als 3 Jahre leprös sind.

Sehr instruktiv sind die Daten nachfolgender Tabelle, welche zeigt, wie früh bereits die Diagnose auf Lepra gestellt werden kann.

Tabelle VII.

Die Dauer der Krankheit betrug bei der Meldung:

	1901	1902	1903		Summa
2 Jahre	35	37	43	=	115
$1^1/_2$ „	14	3	11	=	28
1 „	28	14	31	=	83
$^3/_4$ „	1	8	3	=	12
$^1/_2$ „	17	14	11	=	42
$^1/_4$ „	6	5	3	=	14
$^1/_3$ „	2	3	3	=	8
$^1/_6$ „	1	3	3	=	7
	104	87	108		

Von Interesse war es ferner festzustellen, ob die Früh-Diagnosen nur in denjenigen Gouvernements häufig sind, wo durch Lepraasyle die Kenntnis der Lepra gefördert wird, oder ob auch in anderen Gegenden die Kenntnis der Lepra unter den Aerzten soweit Fortschritte gemacht hat, dass die Diagnose Lepra früh gestellt wird.

Nach den vorhandenen Daten ergibt sich folgendes:

Tabelle VIII.

Die Dauer der Lepra betrug bei der Meldung:

Im Gouvernement:	2 Jahre	$1^1/_2$ Jahr	1 Jahr	weniger als 1 Jahr in:
Livland . . .	25	4	26	15 Fällen
Kuban-Gebiet .	18	2	12	10 „
Astrachan . .	7	2	10	6 „
Kurland . . .	10	2	6	5 „
Estland . . .	6	—	7	6 „
Ufergebiet . .	6	5	3	15 „
Simberck . . .	1	—	—	1 „
Jekatrinoslaw .	3	1	—	3 „
Stawropol . . .	2	—	—	— „
Charkow . . .	2	1	1	1 „
Tiflis	1	—	—	2 „
Terek-Gebiet . .	4	1	2	4 „
Irkutsk . . .	4	1	—	2 „
St. Petersburg .	2	—	1	1 „
Kaluga . . .	1	—	—	1 „

Im Gouvernement:	2 Jahre	$1^1/_2$ Jahr	1 Jahr	weniger als 1 Jahr in:
Eriwan	1	—	—	— „
Kursk . . .	1	—	—	— „
Kowno . . .	1	—	1	— „
Cherson . . .	1	—	—	— „
Twer	1	—	1	— „
Ssaratow . . .	1	—	—	1 „
Nishni Novgorod	1	—	—	— „
Tomsk . . .	1	—	—	— „
Elisabetpol . .	—	—	1	— „
Ural-Gebiet . .	—	—	1	1 „
Pskow	—	—	1	1 „
Orel	—	—	—	1 „
Moskau . . .	—	—	—	1 „
Ssamara . . .	—	—	—	1 „
Taurien . . .	—	—	—	2 „

Hieraus ersieht man, dass in 30 Gouvernements die Fälle relativ früh zur Anzeige kamen, in 21 Gouvernements sogar vor Ablauf des ersten Jahres der Krankheit, der beste Beweis, dass in der Tat die Diagnose relativ früh gestellt werden kann, und dass die Kenntnis der Lepra unter den Aerzten erfreuliche Fortschritte gemacht hat. Es dürfte interessant sein, diese Tabelle nach weiteren 3 Jahren zu vervollständigen.

Einen weiteren Beweis für die Richtigkeit des eben Dargelegten ist auch die Abnahme der spät zur Meldung kommenden Fälle.

Während 1895—1897 noch 180 Fälle erst nach 10—15jährigem Bestehen zur Meldung kamen, so betrug die Zahl derselben 1901—1903 nur 55. Desgleichen ist die Zahl der 5—10 Jahre bestehenden Fälle von 415 auf nur 181 gefallen.

So relativ klein alle diese Ziffern sind, so geben sie uns doch die Bestätigung dessen, dass die Bekämpfung der Lepra auf dem von uns eingeschlagenen Wege bereits Erfolge aufzuweisen beginnt, und die eifrige Tätigkeit der Staatsregierung wie der privater Vereine den verdienten Lohn gewährt und zu weiterer Arbeit anregt.

f) Die Initialsymptome der Lepra.

In den Meldebogen findet sich auch die Frage, an welcher Stelle die ersten Erscheinungen der Krankheit bemerkt worden sind. Vielfach, namentlich bei längerer Zeit bestehender Krankheit, können die Patienten darüber keine genauen Angaben machen, in einer Reihe von Fällen bekommt man jedoch genauere Angaben. Ohne den nachfolgenden Daten eine besondere Bedeutung beilegen zu wollen, scheint es mir immerhin angebracht, dieselben kurz anzuführen.

Tabelle IX.

Die ersten Erscheinungen werden bemerkt

	bei Lepra nodosa	Lepra maculo-nervosa
An d. Gesicht	194	6
„ „ Extremitäten überhaupt	82	34

	bei Lepra nodosa	Lepra maculo-nervosa
An d. Beinen	59	15
" " Armen	36	14
" " Brust	1	3
" " Vorderarmen	23	8
" " Unterschenkeln	33	4
" " Oberschenkeln	6	1
" " Rücken	—	2
" " Nates	2	1
" " Hals	3	—
" " Unterleib	4	—
" " Seite	2	—

Fasst man diese Zahlen zusammen, so ergibt sich, dass bei der Lepra nodosa die Initialerscheinungen zuerst im Gesicht auftraten in 194 Fällen, am Rumpf in 3 Fällen und 239 mal an den Extremitäten. Bei Lepra maculo-nervosa dagegen waren die Initialsymptome nur 6 mal im Gesicht, gegen 76 mal an den Extremitäten und 6 mal am Rumpf.

Diese Angaben bestätigen die in meiner Arbeit über Initialerscheinungen der Lepra (XII. Internationaler Kongress in Moskau 1897) mitgeteilten Beobachtungen, dass die Lepra nodosa vorherrschend die ersten Symptome im Gesicht bietet, während sie bei Lepra maculo-nervosa an den Extremitäten auftreten.

g) Der Beruf der Leprösen.

Meist handelt es sich um Landbewohner, die je nach ihrem Wohnort bald Ackerbau (600), bald Fischerei (58) treiben.

Praktisch wichtig sind die Gewerbe und Beschäftigung der Leprösen, bei denen sie ihre Umgebung der Gefahr der Uebertragung aussetzen, die Verkäufer, Handwerker, Fabrikarbeiter, Bedienung etc.

Es handelte sich 1901—1903 um:

Fabrikarbeiter	25 mal	Kondukteure	2 mal
Handwerker	7 "	Vergolder	1 "
Händler	14 "	Köche	2 "
Dienstleute	11 "	Schuster	3 "
Tischler	18 "	Schneider	4 "
Wächter	6 "	Dachdecker	1 "
Hirten	8 "	Matrosen	2 "
Bettler	10 "	Hausknechte	3 "
Soldaten	10 "	Diener	1 "
Schüler	6 "	Lumpensammler	2 "
Arbeiter	7 "	Fleischer	1 "
Kutscher	5 "	Maschinisten	3 "
Steinhauer	3 "	Böttcher	3 "
Schlosser	2 "	Kellner	2 "
Schmiede	3 "	Feuerwehrmann	1 "
Bäcker	5 "	Gärtner	1 "
Ofensetzer	2 "	Weichensteller	1 "
Fuhrleute	4 "	Typograph	1 "

Dorf-Aeltester . .	1 mal	Schneiderinnen . .	7 mal
Schreiber	2 „	Köchinnen	3 „
Komptorist . . .	1 „	Wärterinnen . . .	4 „
Lehrer	2 „	Wäscherinnen . . .	4 „
Rabbiner	1 „	Beamtenfrau . . .	1 „
Psalmensänger . .	2 „	Feldscherfrau . . .	1 „

Dieses beweist wiederum, dass die Lepra sich vorherrschend in den untersten Klassen der Bevölkerung ausbreitet, die sich nicht genügend der körperlichen Reinigung unterziehen.

Besonders beachtungswert sind die Erkrankungen der Bettler (10) und Hirten (8), sowie der Dienstboten (44). Von den gebildeten Klassen sind nur 2 Lehrer, 1 Rabbiner und 1 Komptorist erkrankt.

h) Die Zahl der isolierten Leprösen.

Von den in den Jahren 1901—3 gemeldeten 764 Leprösen sind bereits 339 in Asylen untergebracht und zwar:

1901	L. nodosa	130	
	L. mac.-nerv.	60	
			190 von 374
1902	L. nodosa	60	
	L. mac.-nerv.	14	
			74 von 219
1903	L. nodosa	61	
	L mac.-nerv.	14	
			75 von 271

Somit sind von 339 in Asylen untergebrachten

L. nodosa 251 von 739
L. mac.-nerv. 88 von 125

Ausserdem haben sich 75 Lepröse häuslicher Isolierung unterzogen und zwar

1901	10
1902	20
1903	45

Hieraus ersieht man, dass auch die Idee sich ausserhalb der Asyle zu isolieren, mehr und mehr Anhang findet und kenne ich mehrere Lepröse der Umgegend St. Petersburgs, sowie in Astrachan, welche die häusliche Isolierung in durchaus befriedigender Weise durchführen, seit einer Reihe von Jahren.

II. Die Lepra-Asyle und -Kolonien in Russland und deren Tätigkeit.

Seitdem Münch (1880) und E. v. Wahl (1887) die Leprafrage für Russland wieder in Anregung gebracht haben, indem sie auf eine unerwartet grosse Anzahl von Leprösen in verschiedenen Gegenden Russlands aufmerksam machten, hat das Interesse für eine Versorgung der Leprösen, sowie die Isolierung derselben als einziges Erfolg ver-

sprechendes Mittel zur Bekämpfung der Lepra nicht aufgehört, Aerzte und Administrativpersonen zu beschäftigen.

Schon Münch schlug, 1887 von der Medizinalverwaltung um seinen Rat befragt, die Einrichtung eines Zentralasyls für Lepröse von seiten des Staates, sowie Hausisolierung in den Dörfern vor. Prof. v. Wahl dagegen versprach sich vorläufig mehr Erfolg von privater Philanthropie und reichte dem Gouverneur von Livland das Projekt einer „Gesellschaft zur Bekämpfung der Lepra im Gouvernement Livland" ein, dessen Statuten am 23. März a. St. 1891 vom Minister des Innern bestätigt wurden. Dank der energischen Tätigkeit v. Wahl's und des noch bis jetzt in eifrigster Weise funktionierenden Vizepräsidenten der Gesellschaft, Prof. Dr. Carl Dehio, wurde bereits am 25. September 1891 das erste Lepraasyl in Muhli, 4 km von Dorpat, für 20 Patienten eröffnet. Das Asyl kostete 3898 R. Es war die erste grössere Summe, die für den Kampf mit der Lepra ausgegeben wurde.

Fast gleichzeitig hatte die Stadt Riga, durch Dr. Ad. v. Bergmann's energische Arbeit für die Leprafrage veranlasst, ebenfalls den Bau eines Lepraasyls auf 40 Betten unternommen, welches ca. 8 km von der Stadt, in einem Tannenwalde angelegt und musterhaft eingerichtet, am 15. Oktober 1891 eröffnet wurde. Bereits nach 1 Jahre musste die Anzahl der Betten auf 80 erhöht werden. Die Kosten des ersten Baues und der Einrichtung, den Grund und Boden nicht gerechnet, machten die bedeutende Summe von 52363 R. aus, ein hübscher Beweis für den hohen kommunalen Sinn der damaligen Stadtverwaltung. 1892 errichtete die Livländische Gesellschaft ihr 2. Asyl in Nennal für 80 Patienten, 9 km vom Dorfe Tschorna.

1893 machte die Leprafrage auch in Kurland bedeutende Fortschritte. Am 31. Januar 1893 wurde die Talsensche Gesellschaft zur Bekämpfung der Lepra in Kurland von der Regierung bestätigt und am 16. April 1893 eine zweite Gesellschaft in Kurland im Kirchspiel Erwahlen des Talsenschen Kreises. Am 20. Januar 1894 wurde sogar ein dritter Verein zur Bekämpfung der Lepra im Bauskeschen Kreise bestätigt, ein Zeichen, wie lebhaft sich die Gutsbesitzer Kurlands für die Leprafrage interessierten. Der Erfolg ist denn auch nicht ausgeblieben. In Kurland sind gegenwärtig 4 Asyle mit 119 Betten vorhanden. Die Regierung ihrerseits förderte diese Unternehmen durch Geldsubsidien. (Der Erwahlensche Verein erhielt 1895 4000 R., der Bauskesche 1896 1500 R. und der Talsensche 1899 14000 R. zum Bau von Asylen.) Seit 1902 erhält die Kurländische Gesellschaft zur Bekämpfung der Lepra 14000 R. jährlich, mit der Bedingung, alle Leprösen unentgeltlich zu verpflegen.

1893 wurden ferner am 18. Oktober die Statuten der „Gesellschaft zur Bekämpfung der Lepra im Gouvernement St. Petersburg" bestätigt und dank der Fürsprache des Gouverneurs, Grafen Toll, geruhte Se. M. der Kaiser Alexander III., der Gesellschaft ein grosses Grundstück in Krutija Rutschji, 24 km von der Station Moloskowiza im Gouvernement St. Petersburg, $3^1/_2$ Stunde Eisenbahnfahrt von der Residenz, sowie 10000 R. zum Bau einer Kolonie zu spenden. Anfangs auf 25 Betten eingerichtet, nach dem System des Referenten, ist sie in stetigem Wachstum begriffen und hat bereits

gegenwärtig Raum für 90 Lepröse. Während die Asyle in den Ostseeprovinzen fast ausschliesslich nur Bewohner dieser Provinzen aufnehmen, nimmt die Kolonie der St. Petersburger Lepra-Gesellschaft auch Lepröse anderer Gouvernements auf, freilich gegen Zahlung, und zwar für Kranke, die noch arbeitsfähig sind, 12 R., für schwere Kranke, die ohne fremde Hülfe sich nicht bewegen können und besonderer Pflege bedürfen, 15 R. monatlich.

Am 2. Dezember 1894 wurde die Kolonie eröffnet, der Bau hat ca. 34000 R. gekostet. Ebenfalls 1894 wurde eine andere Kolonie und zwar für 40—60 Patienten in Ost-Sibirien, 25 km von der Stadt Wiluisk im Jakutskschen Gebiet erbaut, auf Kosten freiwilliger Beiträge, doch erhält der Arzt von der Regierung eine gute Gage und die Rechte des Staatsdienstes mit Vergünstigungen.

1896 eröffnete der Erwahlensche Verein sein Asyl mit 10 Betten, welches jedoch im Laufe des nächsten Jahres auf 32 Betten erweitert wurde.

1896 wurden in Russland 4 neue Asyle eröffnet und zwar 5 km von Talsen ein Asyl mit 32 Betten, sowie von einer Filiale der Talsenschen Gesellschaft in der Nähe von Tukkum ein Asyl mit 10 Betten, welches 1900 in Rauden, 8 km von Tukkum, ein neues Haus mit Raum für 25—30 Patienten erhalten hat.

Ferner eröffnete die Livländische Lepra-Gesellschaft im August 1896 4 km von Wenden ein Asyl mit 60 Betten für die lettischen Bewohner Livlands, während Nennal speziell für den estnischen Theil der Bevölkerung bestimmt ist.

Ausserdem wurde am 1. September 1896 in der nächsten Umgebung der Stadt Astrachan von einem unter dem Präsidium des Gouverneurs stehenden Verein ein Asyl mit 25 Betten eröffnet, jedoch bald auf 40 Betten erweitert, nachdem die Regierung eine einmalige Unterstützung von 10 000 Rubeln votiert und jährlich 500 Rubel zahlt, welche Summe auch die Stadtverwaltung bewilligt hat. Ein besonderes Verdienst um dieses Asyl haben der Gouverneur General v. Hasenkampf und Dr. med. Alejew, der leitende Arzt des Asyls.

Ebenfalls 1896 wurde noch am 20. Dezember in Estland, in dem Dorfe Kuda, ein Asyl mit 60 Betten eröffnet, welches die Estländische Ritterschaft zum Andenken an die Krönung S. M. Kaiser Nikolaus II. gestiftet hat und auch ferner unterhalten wird.

Das Interesse für die traurige Lage der Leprösen, bis in den fernsten Osten gedrungen, veranlasste den General-Gouverneur des Amurgebietes, General-Adjutant Baron Korff, bereits im November 1896 ein Asyl mit 32 Betten in der Nähe der Stadt Nikolajewsk (am Amur) zu gründen und dazu ein Jahresbudget von 7639 R. auszusetzen. In dem darauf folgenden Jahre 1897 wurde ferner eine Kolonie im Dorf Nikolskoje auf Kamtschatka, 45 Kilometer von der Stadt Petropawlovsk mit 25 Betten eingerichtet. Den Unterhalt dieser beiden Anstalten hat die Gesellschaft zur Bekämpfung ansteckender Krankheiten, unter dem hohen Protektorat Ihrer Kaiserl. Hoheit der Prinzessin Eugenie von Oldenburg stehend, übernommen, nachdem die Regierung 16 000 R. zum Bau bewilligt hatte.

1899 hat wiederum die Livländische Gesellschaft ein grosses Asyl

mit 120 Betten auf dem Gut Tarwart im Fellinschen Kreise am 18. Oktober eröffnet, zu dessen Bau die Regierung 27 000 R. beigetragen sowie ein Grundstück gespendet hat. (Die ganze Bausumme betrug 47 000 R.) Somit hat die Livländische Gesellschaft zur Bekämpfung der Lepra in den ersten 10 Jahren ihres Bestehens 4 Asyle mit im ganzen 270 Betten geschaffen, deren Baueinrichtung 111 677 R. gekostet hat. Die Gesamtausgaben betrugen in dieser Zeit 205 936 R. Ein grosser Schritt in der Verpflegung der Leprösen ist dadurch gemacht worden, dass die Ritterschaft Livlands die Kosten der Verpflegung übernommen hat, die, wie erwähnt, eine Summe von circa 12 000 R. jährlich ausmacht.

1900 übernahm die Gesellschaft des „Roten Kreuzes“ die Anlage eines zweckentsprechenden Lepra-Asyls in Taschkent für 60 Pat., und in demselben Jahre hat der Astrachansche Verein ein Asyl in Krasnojar mit 10 Betten (Gouvernement Astrachan) eröffnet.

1901 ist ausserdem ein Asyl mit ca. 40 Betten im Kuban-Gebiet aus privaten Mitteln und Schenkungen eröffnet worden, doch soll es vom Kriegsministerium übernommen werden.

In Aussicht stehen noch je ein Asyl in Bessarabien (im Kreise Ismaïl, in der Nähe der Grenze Rumäniens; das Geld ist bereits bewilligt, doch handelt es sich nur noch um die Wahl des Ortes), sowie in Eriwan (Transkaukasien) auf Kosten der Regierung. Desgleichen errichtet das Kriegsministerium ein Lepra-Asyl für das Don-Kosaken-Gebiet. Auch für Sibirien sind 2 neue Asyle in Aussicht genommen.

Aus dem Dargelegten ersieht man, dass zu den bereits 1897 bestehenden 13 Asylen und Kolonien, die in den letzten 7 Jahren bedeutend erweitert worden sind, noch 5 neue hinzugekommen sind, so dass somit Russland gegenwärtig — 1904 — im ganzen 4 Kolonien und 14 Asyle für Lepröse, also 18 Anstalten bereits in Tätigkeit und 5 neue in Aussicht hat.

Die Anzahl der vorhandenen 866 Plätze für Lepröse verteilt sich in folgender Weise:

Livland:	Muhli	20 Betten,	
	Numal	80 „	
	Riga	80 „	
	Wenden	60 „	
	Tarwost	120 „	
			360 Betten.
Kurland:	Talcun	32 Betten,	
	Tubkum	30 „	
	Bauske	25 „	
	Erwahlen	32 „	
			119 „
		Latus	479 Betten.

		Transport	479 Betten.
Estland:	Kuda		60 „
Gouv. St. Petersburg:	Krutija Rutschji		80 (bis 90)
Gouv. Astrachan:	Astrachan	40 Betten,	
	Krasusjarsk . . .	10 „	
			50 Betten,
Kaukasus:	Kuban-Gebiet		40 „
Turkestan			40 „
Sibirien (Wilnisk)			60 „
Amur-Gebiet:	Nikolajewsk . .	32 Betten,	
	Dorf Nikolskoje .	25 „	
			57 „
		Im ganzen	**866** Betten.

Ausserdem besteht in Helsingfors ein Lepra-Asyl mit ca. 20 Betten, jedoch ist für Finnland das Projekt eines grösseren Asyls bereits fertig gestellt, da in Finnland bereits 1901 53 Lepröse registriert waren.

Ueber die Krankenzahl in den Leproserien liegen genauere Daten für Livland, Kurland, die St. Petersburger Kolonie und Astrachan vor, laut gedruckter Berichte.

In **Livland** waren in den Leproserien vorhanden:

am 1. 1. 1897	131 Lepröse
„ 1. 1. 1898	143 „
„ 1. 1. 1899	137 „
„ 1. 1. 1900	165 „
„ 1. 1. 1901	168 „
„ 1. 1. 1902	196 „
„ 1. 1. 1903	184 „
„ 1. 1. 1904	177 „

Das Rigasche städtische Lepra-Asyl.

		Aufgen.	Ausgetreten.	Gestorben.
1. 1. 1897	87 Lepröse	26	12	7
1. 1. 1898	68 „	25	9	12
1. 1. 1899	72 „	29	14	11
1. 1. 1900	76 „	24	13	17
1. 1. 1901	70 „	23	9	16
1. 1. 1902	68 „	17	13	7
1. 1. 1903	65 „	35	19	8
1. 1. 1904	73 „	—	—	—

In 7 Jahren 78 Lepröse gestorben.

a) Im Asyl Muhli:

	Vorhanden.	Aufgen.	Gestorben.	Uebergeführt.
1. 1. 1897	17	15	0	18
1. 1. 1898	14	16	0	7
1. 1. 1899	16	10	1	17
1. 1. 1900	8	11	2	3

	Vorhanden.	Aufgen.	Gestorben.	Uebergeführt.
1. 1. 1901	14	5	—	6
1. 1. 1902	13	4	—	—
1. 1. 1903	17	—	—	1 Entl. od.
1. 1. 1904	16	—	—	übergeführt.

b) Nunnal.

	Vorhanden.	Aufgen.	Gestorben.	Uebergeführt.
1. 1. 1897	57	42	10	21
1. 1. 1898	68	29	17	20
1. 1. 1899	60	29	9	34
1. 1. 1900	46	2	5	13
1. 1. 1901	30	20	3	6
1. 1. 1902	41	—	—	—
1. 1. 1903	31	—	—	—
1. 1. 1904	22	—	—	—

c) Wenden.

	Vorhanden.	Aufgen.	Gestorben.	Uebergeführt.
1. 1. 1897	57	25	12	10
1. 1. 1898	61	10	3	7
1. 1. 1899	61	17	13	6
1. 1. 1900	59	14	5	8
1. 1. 1901	60	18	11	8
1. 1. 1902	59	—	—	—
1. 1. 1903	56	—	—	—
1. 1. 1904	57	—	—	—

d) Tarwast.

	Vorhanden.	Aufgen.	Gestorben.	Ausgetreten.
1. 1. 1899	—	53	1	0
1. 1. 1900	52	29	3	14
1. 1. 1901	64	31	5	7
1. 1. 1902	83	—	—	—
1. 1. 1903	86	—	—	—
1. 1. 1904	82	—	—	—

Kurland.

a) Talsen.

	Vorhanden.	Aufgen.	Ausgetreten.
1. 1. 1898	26	3	6
1. 1. 1899	23	9	7
1. 1. 1900	25	7	6
1. 1. 1901	26	—	—

b) Tukkum.

	Vorhanden.	Aufgen.	Ausgetreten.
1. 1. 1898	12	2	2
1. 1. 1899	12	3	1
1. 1. 1900	14	8	4
1. 1. 1901	18	—	—

c) Erwahlen.

	Vorhanden.	Aufgen.	Ausgetreten.
1. 1. 1898	11	3	2
1. 1. 1899	12	12	4
1. 1. 1900	20	5	3
1. 1. 1901	22	—	—

d) Bauske.

	Vorhanden.	Aufgen.	Ausgetreten.
1. 1. 1898	8	6	1
1. 1. 1899	13	3	4
1. 1. 1900	12	2	2
1. 1. 1901	12	—	—

Gouvernement St. Petersburg.

Kolonie Krutija Rutschji.

	Vorhanden.	Aufgen.	Gestorben.	Ausgetreten.
2. 12. 1894	—	9	1	0
1. 1. 1895	8	16	6	6
1. 1. 1896	12	11	—	3
1. 1. 1897	20	15	1	4
1. 1. 1898	30	11	1	4
1. 1. 1899	36	22	4	7
1. 1. 1900	47	31	7	7
1. 1. 1901	64	27	11	6
1. 1. 1902	74	22	12	12
1. 1. 1903	73	—	—	—

Aus diesen Zahlen ersieht man, wie die Zahl der Verpflegten in stetiger Steigerung begriffen ist, trotz der hohen Mortalitätsziffer der letzten Jahre, die durch Aussterben der in den ersten Jahren des Bestehens der Kolonie Eingetretenen verursacht sind.

Gouvernement Astrachan.

Asyl bei Astrachan.

	Vorhanden.	Aufgen.	Gestorben.	Ausgetreten.
1. 1. 1897	20	20	17	
1. 1. 1898	23	28	39	
1. 1. 1899	29	30	23	
1. 1. 1900	36	—	—	—
1. 1. 1901	40	21	8	15
1. 1. 1902	38	26	12	15
1. 1. 1903	37	18	10	16
1. 1. 1904	29	—	—	—

Auch ist die Mortalität eine recht hohe, da viele Patienten in späteren Stadien erst ins Asyl kommen.

Bezüglich der nicht geringen Zahl der „Ausgetretenen“ muss noch erwähnt werden, dass für Russland keine Zwangs-Internierung in praxi besteht, obgleich sie nach dem Gesetz für Infektionskrankheiten wohl möglich wäre. Selbstverständlich suchen die Aerzte die Leprösen zum Verbleiben in den Anstalten zu bereden, besonders solange sie noch offene Wunden haben. Wenn trotzdem jährlich eine Anzahl austritt und in die Heimat zieht, so ist das meist nicht auf lange, gewöhnlich kehren die Patienten bald wieder zurück. Diese austretenden Patienten sind übrigens meist auch nicht so gefährlich für ihre Umgebung, da sie im Asyl gelernt haben, die nötigen Vorsichtsmassregeln zu ergreifen.

Ueber die nicht geringen Ausgaben sowohl von seiten der privaten Gesellschaften, wie auch von der russischen Regierung möchten wir folgendes mitteilen.

Die Livländische Gesellschaft zur Bekämpfung der Lepra hat in den ersten 10 Jahren ihres Bestehens

eingenommen . . . . 208 936 R.
ausgegeben . . . . 205 936 R.

Der Bau der 4 Asyle hat 111667 R. gekostet, davon hat die Regierung dem Verein 27000 R. gespendet.

Der Unterhalt des Rigaschen Städtischen Lepra-Asyls hat gekostet:

1892	9 655 R.	1898	15 074 R.
1893	10 678 „	1899	16 875 „
1894	13 074 „	1900	19 689 „
1895	13 488 „	1901	19 628 „
1896	12 999 „	1902	19 503 „
1897	14 503 „	1903	20 899 „

Die Kurländischen Lepra-Vereine haben auch, wie schon erwähnt, wiederholt Staatssubsidien zum Bau der Asyle erhalten, im ganzen 19 500 R.

Die St. Petersburger Lepra-Gesellschaft hat bei ihrer Gründung durch S. M. Alexander III. 10 000 R. erhalten und im Jahre 1900 von der Regierung 20 000 R.

Ferner hat die Regierung dem Leprosorium in Astrachan 1898 ebenfalls eine Spende von 10 000 R. zukommen lassen und dem Asyl im Amurgebiet in Nikolajewsk ebenfalls 10 000 R.

Die Asyle im Kaukasus und im Gebiet der Don-Kosaken wurden auf Kosten des Kriegsministeriums errichtet, da sich die Gebiete unter Militärverwaltung befinden.

Nähere Daten über die Einnahmen und Ausgaben kann ich nur für die St. Petersburger Lepra-Gesellschaft, sowie für die Kurländischen Vereine und das Astrachansche Asyl geben, für letzteres allerdings nur für 3 Jahre, doch auch diese Zahlen geben einen kleinen Ueberblick über die finanzielle Seite der Leprafrage, wenn man sie mit den Zahlen der Krankenbewegung vergleicht.

St. Petersburger Lepra-Gesellschaft:

	Einnahmen	Ausgaben	Kapital
1895	11 701 R.	10 882 R.	21 050 R.
1896	10 729 „	11 627 „	21 050 „
1897	14 955 „	12 320 „	23 150 „
1898	37 190 „	9 457 „	51 350 „
1899	16 081 „	11 244 „	—
1900	32 317 „	18 450 „	70 015 „
1901	13 274 „	13 481 „	68 300 „
1902	15 232 „	14 251 „	68 300 „

Die erhöhten Ausgaben 1900 erklären sich durch den Bau neuer Baracken.

Die Kurländischen Lepra-Gesellschaften:

a) Erwahlensche Verein:

	Einnahmen	Ausgaben
1896	7 890 R.	5 442 R.
1897	4 724 „	4 508 „
1898	4 172 „	3 529 „

b) Bauskesche Verein:

	Einnahmen	Ausgaben
1896	3 135 R.	1 197 R.
1897	1 162 „	2 182 „
1898	1 228 „	1 155 „

c) Talsussche Verein.

	Einnahmen	Ausgaben
1896	13 953 R.	4 769 R.
1897	19 560 „	6 845 „
1898	5 415 „	4 562 „
1899	7 362 „	4 343 „
1900	8 865 „	8 633 „

d) Tukkensche Filiale des Talsusschen Vereins.

	Einnahmen	Ausgaben
1896	1 601 R.	1 575 R.
1897	405 „	293 „
1898	1 181 „	963 „
1899	3 534 „	1 078 „
1900	9 520 „	7 586 „

Von dem Astrachan'schen Komitée des Lepra-Asyls finden wir über den finanziellen Teil seiner Tätigkeit in den gedruckten Berichten folgendes: (s. nebenstehende Tabelle.)

Somit hat das Astrachansche Komitee in 8 Jahren 30 401 R. eingenommen und 27 179 R. ausgegeben, wobei 180 Lepröse verpflegt wurden. Es mag manchem die Summe unverhältnismässig gross erscheinen bei der geringen Anzahl der Verpflegten, doch löst sich dieses scheinbare Missverhältnis leicht, wenn man bedenkt, dass die Lepra-Asyle nicht nur den Zweck haben, die Leprösen zu verpflegen, sondern durch deren Isolierung auch die Verbreitung der Lepra zu bekämpfen.

	Kapital	Einnahmen	Ausgaben
1896	— R.	9 164 R.	2 012 R.
1897	7 150 „	3 030 „	3 401 „
1898	7 443 „	3 409 „	3 622 „
1899	7 229 „	3 356 „	3 479 „
1900	f e h l t		
1901	14 178 „	3 657 „	5 936 „[1])
1902	11 899 „	3 362 „	4 438 „
1903	10 622 „	4 833 „	4 291 „
		30 461 R.	27 179 R.

Und in dieser Hinsicht hat die Kaiserl. russische Regierung durch die Bestätigung und Förderung der Lepra-Vereine, sowie durch die Einrichtung staatlicher Leproserien einen bedeutenden Schritt zur Bekämpfung der Lepra getan, und zwar zu einer Zeit, wo diese Seuche noch relativ geringe Verbreitung hat. Alles dieses war natürlich nur von dem Moment an möglich, wo es anerkannt wurde, dass es sich um eine durch Uebertragung sich ausbreitende Krankheit handelt. Solange die Anschauung herrschte, dass die Lepra nicht kontagiös sei, wurden auch keine Massregeln zur Isolierung vorgenommen, für die Leprösen wurde nicht gesorgt und die Zahl derselben vergrösserte sich. Hätten die Gegner der Kontagiosität wenigstens für die Verpflegung der Leprösen gesorgt, statt gegen die Vertreter der Kontagiosität zu kämpfen, so wären wir in Russland schon noch weiter mit der Bekämpfung der Lepra, da die Hauptsache doch immer die Isolierung und Verpflegung der Leprösen (sei es in Anstalten, sei es häusliche Isolierung) ist.

III. Die Massregeln der Regierung bezüglich der Bekämpfung der Lepra in Russland.

1. Die wichtigste der Regierungsmassregeln war das Zirkular an sämtliche Gouverneure vom 18. April 1895, welches die Meldepflicht für die Leprösen eingeführt und dadurch die Möglichkeit geschaffen hat, regelrechte Daten über die Verbreitung der Lepra zu sammeln.

2. Ferner bestätigt die Regierung ohne Schwierigkeiten „Vereine zur Bekämpfung der Lepra" und unterstützt sie nach Möglichkeit materiell zum Bau von Leproserien und richtet Asyle auf Staatskosten ein.

3. Entsprechend der Verordnung der Kaiserl. Deutschen Reichs-Regierung von 1900, welche den Oberpräsidenten in Berlin, Danzig und Königsberg untersagt Leprösen Pässe nach Russland auszureichen, hat die Kaiserl. Russische Regierung 1901 ebenfalls dieselbe Verordnung erlassen und speziell den Gouverneuren von Kowno, Kurland, Estland, Bessarabien, St. Petersburg, dem Warschauer General-Gouverneur, dem Chef der Landes-Verwaltung des Kaukasus und dem Kriegs-Ministerium (unter dessen Verwaltung Turkestan steht) mitgeteilt.

4. Nachdem der Medizinalrat, die oberste medizinische Institution,

1) Darunter 1000 R. zum Bau des Asyls in Krasnojar.

eingehendere Beratungen über Massregeln gegen die Verbreitung der Lepra abgehalten, hat das Medizinal-Departement folgendes Zirkular an sämtliche Gouverneure am 24. April 1902 No. 4429 erlassen:

An das Ministerium des Innern sind wiederholt von seiten der Herrn Gouverneure Anfragen gelangt, ob die Lepra zur Zahl der ansteckenden Krankheiten gerechnet wird und ob die Leprösen zwangsweiser Isolierung unterzogen werden können.

Infolgedessen ist über die Frage der Kontagiosität der Lepra im Medizinalrat verhandelt worden, welcher laut Journal vom 26. März cr., sub. No. 206, bestätigt vom H. Gehilfen des Ministers des Innern, anerkannt hat: Da bisher die Kontagiosität einiger Formen der Lepra auf wissenschaftlichem Wege noch nicht wiederlegt ist, kann man für diese Formen der Lepra diejenigen Gesetzesparagraphen anwenden, welche sich auf die Vorbeugung und Bekämpfung der Ausbreitung ansteckender Krankheiten beziehen (Gesetzes-Sammlung Band XIII, Aerztliches Statut, Teil II, Abteil. I; Band XI Statut der Industrie; Band XII, Grundlagen über Mieten von Dorfarbeitern; Band XV, Ueber Strafen.

Ferner hat der Medizinalrat laut Journal vom 9. April cr., sub. No. 242, bestätigt durch den H. Gehilfen des Ministers des Innern, anerkannt, dass in den konstatierten Fällen von Lepra man sich bei der weiteren Versorgung derselben an folgende Regeln zu halten hat;

1. In jedem Gouvernement, in welchem Fälle von Lepra beobachtet worden, muss eine spezielle Kommission gebildet werden, deren Glieder vom Gouverneur bestimmt werden, doch muss der Medizinal-Inspektor Mitglied derselben sein, desgleichen nicht weniger als 2 Aerzte, die mit der Lepra bekannt sind.

Die Kommission hat die Aufgabe, in jedem einzelnen Falle nicht nur festzustellen, ob er sich im infektiösen Stadium befindet, sondern auch unter welchen Verhältnissen der Patient lebt und ob dieselben derartig, dass für die Umgebung Ansteckungsgefahr vorhanden, resp. ob eine zweckentsprechende häusliche Isolierung möglich ist.

2. In denjenigen Fällen von Lepra im infektiösen Stadium, wo die häuslichen Verhältnisse derartig sind, dass beim Verbleiben des Patienten zu Hause, nach Ansicht der Kommission, die Umgebung nicht vor der Möglichkeit einer Uebertragung geschützt ist, muss eine Isolierung angewandt werden, wie sie nach den oben angeführten Gesetzesparagraphen für ansteckende Krankheiten vorgeschrieben.

3. Dem ärztlichen Personal des Gouvernements wird es zur Pflicht gemacht, über alle, der häuslichen Isolierung unterzogenen Leprösen zu wachen und in denjenigen Fällen, wo die Isolierung zu Hause nicht durchgeführt wird, der Kommission sofort davon Anzeige zu machen.

4. Falls bei einem in einer Leproserie sich befindenden Patienten von dem Anstaltsarzt konstatiert wird, dass das infektiöse Stadium aufgehört hat und Patient den Wunsch äussert, in die Heimat zurückzukehren, kann er entlassen werden, nachdem er von der Kommission besichtigt worden und dieselbe sich ebenfalls für Entlassung ausgesprochen.

5) Ein Lepröser in der infektiösen Periode, der sich in einer Le-

prosorie befindet, wohin er von der Kommission gesandt worden ist, kann von derselben wieder entlassen und den Verwandten übergeben werden, wenn dieselben Beweise bringen, dass die Vermögensverhältnisse des Patienten oder seiner Verwandten derartig sind, dass mit allen nötigen Vorsichtsmassregeln die häusliche Isolierung durchgeführt werden kann.

6) Die Regeln der häuslichen Isolierung Lepröser werden von den Medizinalabteilungen festgestellt und der Kommission mitgeteilt.

7) Beim Transport Lepröser hat man sich an das Zirkular des Ministeriums des Innern vom 20. Februar 1900 sub. N. 307 zu halten. (Dasselbe ist jedoch 1903 bereits einer Abänderung unterzogen. Ref.)

Indem das Medizinal-Departement die oben angeführten Verordnungen des Medizinalrates zur Kenntnis und Anwendung Eurer Exzellenz mitteilt, hat es die Ehre zu bitten, die Projekte der in § 1 und 6 erwähnten Instruktionen und Regeln, nach ihrer Ausarbeitung dem Departement mitzuteilen, zum Vortrag an den Herrn Minister des Innern.

Unterzeichnet: Direktor Ragosin.

5) Am 21. Oktober 1903 sub. N. 112 sind in der „Sammlung der Regierungs-Erlasse" Zeitweilige Regeln für den Transport Geisteskranker, von tollen Hunden Gebissener und Lepröser veröffentlicht.

In denselben heisst es in

§ 1. Falls man Lepröse in einer besonderen Waggonabteilung per Eisenbahn transportieren lassen will, hat man dem Stationsvorsteher ein medizinisches Zeugnis vorzulegen, in welchem gesagt ist, dass der Patient nach der Art seines Leidens einer besonderen Waggonabteilung bedarf.

Im § 2. Es ist erwünscht, dass die Anzeige möglichst rechtzeitig geschehe, damit man für eine besondere Abteilung sorgen könne.

Im § 4. Lepröse, die eine besondere Abteilung nötig haben, müssen einen Begleiter haben.

Im § 5. Auf den Endstationen, auf dem die Leprösen den Waggon verlassen, sind die Abteilungen zu desinfizieren, wozu ein 3 tägiger Termin gegeben wird.

Der Transport Lepröser hat wiederholt zu Schwierigkeiten Veranlassung gegeben, doch lassen sich die bisher erlassenen Verordnungen nicht immer strikt durchführen. Den Leprösen, die sich freiwillig in Leproserien begeben, kann man doch keinen Begleiter mitgeben und wer soll das tun resp. bezahlen.

Die in dem Zirkular vom 24. April 1902 erwähnten Kommissionen sind bisher noch nicht in Funktion getreten, wenigstens sind mir keine Instruktionen derselben zu Gesicht gekommen. Doch auch diese Kommissionen werden über keine Mittel verfügen.

Die Frage scheint mir auch insofern nicht von zu grosser Wichtigkeit, da die ulzerierten Partien bei den Leprösen, wenn sie sich auf Reisen begeben, doch fast stets verbunden sind und somit der Umgebung keinerlei Gefahr droht.

Die Verordnung, den Patienten besondere Abteilungen in den Waggons einzuräumen, ist durchaus empfehlenswert, lässt sich aber auch nur durchführen, wenn die Leprösen aus einer Klinik oder einem Hospital in eine Leproserie gesandt werden.

Ferner ist in der Verordnung kein Unterschied zwischen Lepra nodosa und Lepra maculonervosa gemacht. Letztere bieten, solange keine Ulzerationen vorhanden, keinerlei Gefahr für die Umgebung, brauchen also weder Begleiter, die für sie sorgen, noch besondere Waggonabteilungen. — Die Verordnung über den Transport Lepröser ist, wie wir dieses zur Erklärung beifügen wollen, nicht vom Medizinaldepartement, sondern von dem Ministerium der Wegekommunikationen ausgearbeitet worden, ohne Spezialisten hinzuzuziehen. Sie ist gut gemeint, jedoch nicht praktisch durchführbar, jedoch schon zweckmässiger als die vorhergehende Verordnung, nach welcher für jeden Leprösen ein besonderer Waggon 2 Wochen vor der Abfertigung bestellt werden sollte. Wir führen dieses an, um zu zeigen, wie wenig bei der Frage von „ansteckenden Krankheiten“ der Grad der Infektiosität berücksichtigt wird.

6) Im Jahre 1901 wurde von dem Ministerium der Volksaufklärung (Unterrichts-Ministerium) dem Medizinal-Departement die Frage vorgelegt, ob man in den Volksschulen die Kinder lepröser Eltern zum Schulbesuch zulassen könne.

Das Medizinal-Departement hat diese Frage in folgender Weise beantwortet, nachdem sie verschiedene Leprologen um ihre Ansicht befragt:

1. Die Kinder lepröser Eltern müssen beim Eintritt in die Volks-Schulen einer ärztlichen Besichtigung unterzogen werden und sind zum Unterricht zuzulassen, wenn sie keinerlei Erscheinungen von Lepra aufweisen.

2. Dieselben unterliegen ständiger medizinischer Aufsicht und werden aus der Schule entfernt, sobald sich Symptome von Lepra zeigen.

IV. Die Beschäftigung der Leprösen in Anstalten.

Es ist durchaus prinzipiell wünschenswert und human, die Leprösen derartig beständig zu beschäftigen, dass sie möglichst wenig Zeit haben, über das ihnen bescherte traurige Los zu grübeln und nachzudenken.

Die praktische Durçhführung bietet jedoch vielfache Schwierigkeiten, da eine Reihe Lepröser kranke Extremitäten sowie häufig Augenaffektionen haben, sodass sie in der Tat völlig arbeitsunfähig sind. Auch die nicht geringe Anzahl gerade im hohen Alter Erkrankender, wo sie überhaupt schon an Altersschwäche leiden, sind nicht zum Arbeiten zu benutzen. Andererseits haben wir aber eine Anzahl vollkommen arbeitsfähiger Lepröser, von der jedoch ein Teil direkt arbeitsunlustig ist, von der falschen Anschauung ausgehend, sie brauchen nicht zu arbeiten, da sie krank seien.

Um die Leprösen zur Arbeit anzuregen, wird in der Kolonie Krutije Rutschji den Kranken die Arbeit durch besondere Vergünstigungen oder gar durch Geld honoriert. Namentlich hat sich diese Methode bei solchen Patienten als praktisch erwiesen, welche Familien in der Heimat haben, welcher sie auf diese Weise eine Hülfe zukommen lassen können. So z. B. haben wir in der erwähnten Kolonie einen orthodoxen Priester aus Süd-Russland, den wir als Anstaltspriester mit

Gehalt angestellt haben, von dem er den grössten Teil seiner Familie sendet.

Ferner haben wir alle Tischler-, Schneider- und Schuhmacher-Arbeit, sowie alle Feldarbeiten durch unsere Leprösen besorgen lassen, ihnen dafür gezahlt und doch noch eine Oekonomie gemacht.

Auch in anderen Anstalten wird dieses Prinzip nach Möglichkeit durchgeführt, doch klagt man überall über eine gewisse Arbeitsunlust der Leprösen.

V. Die Lage der Leprösen in den Hospitälern und Kliniken.

In den Hospitälern werden die Kranken nur ungern gehalten, da keine besonderen Abteilungen vorhanden sind und sie mit anderen Infektionskranken zusammen liegen, was durchaus nicht wünschenswert ist. Meist werden die Leprösen früher oder später in Lepra-Asyle abgefertigt, doch ist es nicht leicht, sie dazu zu bewegen. Zwangsweise Entfernung aus dem Hospital ins Asyl, dazu hat ein Hospital kein Recht. Wollen die Patienten austreten, so suchen wir sie durch Bereden davon abzuhalten, jedoch wird über jeden Austritt eines Leprösen der Medizinal-Inspektor davon in Kenntnis gesetzt, der Anordnung zu treffen hat, dass der Lepröse auch weiter unter ärztlicher Aufsicht bleibe. Ein Monate dauernder Hospitalaufenthalt ist entschieden für Lepröse nicht günstig, da sie unter langer Weile leiden.

Schwierig ist auch die Frage des Aufenthalts Lepröser in Kliniken. Es ist durchaus notwendig, den Studenten und Aerzten die Möglichkeit zu bieten, sich mit der Lepra bekannt zu machen und daher Lepröse in die Kliniken aufzunehmen, doch ist es angebracht, dieselben in besonderen Zimmern, nicht mit Anderen zusammen zu legen.

Sehr empfehlenswert ist eine systematische Organisation des Besuches der Lepra-Asyle von Seiten der Professoren der Dermatologie gemeinsam mit ihren Zuhörern, wie ich das alljährlich mit Aerzten meiner Kurse am Kaiserl. klinischen Institut der Grossfürstin Helene Pawlowna seit einer Reihe von Jahren durchführe, doch gibt es leider auch Professoren der Dermatologie, die noch nie ein Lepra-Asyl besucht haben.

Die Isolierung Lepröser in einem besonderen Zimmer würde dem System der häuslichen Isolierung nahe kommen.

Sehr vorsichtig muss man mit dem Docieren in Gegenwart der Leprösen sein, namentlich wenn man nicht von der Kontagiosität der Lepra überzeugt ist. Es ist schon vorgekommen, dass sich dann Lepröse darauf berufen, in der Klinik hätte man gesagt, ihre Krankheit sei nicht ansteckend, folglich brauchen sie auch nicht in ein Lepra-Asyl zu gehen. Und doch senden die Kliniken ihre Leprösen schliesslich in die Leproserien.

Schlussbemerkungen.

Wenn wir den Stand der Leprafrage von 1897 mit demjenigen von 1904 vergleichen, müssen wir mit einer gewissen moralischen Be-

friedigung hervorheben, dass in diesen letzten 7 Jahren auf dem Gebiete der Bekämpfung der Lepra in Russland entschiedene Erfolge zu konstatieren sind und zwar:

1. Die Registrierung geht erfolgreich vor sich.

2. Die Leprafälle kommen jetzt in früheren Stadien zur Anzeige als vor 7 Jahren.

3. Die Zahl der Leprosorien nimmt zu, insbesondere dank der materiellen Unterstützung seitens der Staatsregierung, die ebenfalls Asyle zu gründen beginnt.

4. Russland verfügt bereits über 18 Leproserien mit Raum für 866 Lepröse, und 5 weitere Anstalten sind in nächster Zeit in Aussicht genommen.

Schweden.

Bericht

von

E. Sederholm in Stockholm.

Ende des Jahres 1896 gab es in Schweden 70 sicher erkannte Fälle von Lepra. Ende des Jahres 1903 war deren Zahl 68 (Tab. 1). Es scheint also, als ob die fakultative Isolierung von keinem Einfluss auf die Frequenz der Lepra gewesen wäre. Aber dabei muss in Betracht gezogen werden, dass die Zahl von 1896 sicher zu niedrig gewesen ist. Das Suchen nach bisher unbekannten Leprafällen ist nämlich während dieser ganzen Zeit ziemlich energisch betrieben worden und die Zahl solcher neuen Fälle ist eine ziemlich grosse gewesen, besonders in Gegenden ausserhalb Helsinglands. In dieser Provinz wird die Erforschung von neuen Fällen seit 33 Jahren systematisch von einem besonders dazu beauftragten Arzte ausgeführt und es ist anzunehmen, dass die meisten neuen Fälle in dieser Gegend ziemlich bald nach ihrem Entstehen erkannt und verzeichnet werden. In anderen Gegenden, besonders in Dalarne, kommt es dagegen oft vor, dass Fälle, die schon seit langer Zeit bestehen, zufällig entdeckt werden.

Dass die fakultative Isolierung einer Zwangsisolierung in prophylaktischer Hinsicht unterlegen ist, lässt sich nicht bezweifeln. Da man aber genötigt ist mit einem solchen System gegen die Lepra zu arbeiten, was bei uns wenigstens bis jetzt notwendig gewesen ist, muss man sein Augenmerk darauf richten, dass von den besonders ansteckenden (tuberösen) Fällen so viele wie nur möglich isoliert werden. Wo eine beständige anhaltende ärztliche Ueberwachung stattgefunden hat (in Helsingland), ist auch dies so ziemlich gelungen, was aus Taf. 2 hervorgeht. Der Isolierungsprozent der Tuberösen in Helsingland ist während dieser 7 Jahre von 38 bis auf 75 % gestiegen, während die entsprechenden Zahlen für die übrigen Gegenden Schwedens zusammengenommen (Tab. 2) kaum eine Besserung aufweisen. Im Zusammenhang damit ist die ganze Anzahl der Leprösen in Helsingland bedeutend gesunken (von 122 im Jahre 1874 auf 35 im Jahre 1903). Man kann also sagen, dass das hiesige System für die nächste Umgebung des Asyles Gutes geleistet hat. — Vielleicht könnte

man noch besser die Isolierung der ansteckungsgefährlichen Fälle durchführen, wenn noch ein Lepraasyl eingerichtet würde. Dieses sollte dann nach Dalarne verlegt werden, wo jetzt 15 sicher erkannte und noch einige zweifelhafte Fälle in ihren resp. Heimstätten unge-

Tabelle 1.

Fälle von Lepra in ganz Schweden.

Ende des Jahres	Lepra tuberosa				Lepra maculo-anaesthetica			
	Im Krankenhause	In der Heimat	Summa	Isolierungsprozent	Im Krankenhause	In der Heimat	Summa	Isolierungsprozent
1897	16	24	40	40,0	17	15	32	53,1
1898	17	23	40	42,5	17	16	33	51,5
1899	21	25	46	45,6	18	9	27	66,7
1900	22	23	45	48,9	16	11	27	59,3
1901	18	20	38	47,4	16	14	30	53,3
1902	19	19	38	50,0	17	13	30	56,7
1903	25	18	43	58,1	16	9	25	64,0

Tabelle 2.

Fälle von Lepra tuberosa in Schweden.

Ende des Jahres	Provinz Helsingland				Andere Provinzen Schwedens			
	Im Krankenhause	In der Heimat	Summa	Isolierungsprozent	Im Krankenhause	In der Heimat	Summa	Isolierungsprozent
1897	5	8	13	38,5	11	16	27	40,7
1898	5	11	16	31,3	12	12	24	50,0
1899	10	12	22	45,5	11	13	23	47,8
1900	12	7	19	63,2	10	16	26	38,6
1901	11	5	16	68,8	7	15	22	31,8
1902	12	6	18	66,7	7	13	20	35,0
1903	15	5	20	75,0	10	13	23	43,5

Tabelle 2.

Die Krankenbewegung in dem Lepraasyl zu Jerfsy (Schweden).

Jahr	Zahl der Insassen am Anfang des Jahres	Aufgenommen	Abgang		Zahl der Insassen am Ende des Jahres
			Tote	ungeheilt entlassen	
1897	30	16	13	—	33
1898	33	7	6	—	34
1899	34	9	2	2	39
1900	39	12	8	5	38
1901	38	7	9	2	34
1902	34	12	6	4	36
1903	36	10	3	2	41

nügend oder garnicht isoliert sich befinden. Dies zusammen mit der Anordnung einer ärztlichen Ueberwachung sämtlicher Leprösen der Provinz auf dieselbe Weise wie in Helsingland angeordnet, würde wahrscheinlich dieselben günstigen Wirkungen gegen die Verbreitung der Krankheit wie dort ausüben. Es hat sich nämlich gezeigt, dass die Kranken in Dalarne sich ganz besonders dagegen sträuben, ihre Heimat zu verlassen, um in eine andere Provinz zu übersiedeln.

Was die Belegung der 50 Plätze des Lepraasyles zu Jerfsö betrifft, sind sie niemals vollständig besetzt worden. Eine Uebersicht von der Krankenbewegung gibt Tab. 3. Daraus geht auch hervor, wie die Zahl der ungeheilt Ausgetretenen in dem letzten Jahre zugenommen hat.

Schweden.

Massregeln zur Bekämpfung der Lepra von 1897—1903.

Auf Vorschlag der Medizinaldirektion wurde den 28. Januar 1898 eine Aenderung in den geltenden Verordnungen eingeführt, so dass Lepra in gewissen Beziehungen den akuten ansteckenden Krankheiten gleichgestellt wurde. Für diese Krankheit wurde die Anzeigepflicht eingeführt. Jeder Arzt, welcher von einem Fall von Aussatz Kenntnis erhält, soll dies der Behörde in der Heimat des Kranken anmelden. Auf Anzeige dieser Behörde kann der Kreisphysikus aufgefordert werden, auf öffentliche Kosten den Kranken zu besuchen und zu dessen Isolierung und Behandlung Rat zu erteilen. Wo die Diagnose unsicher ist, kann die Medizinaldirektion einen Spezialisten beauftragen, den Fall zu untersuchen. Im Lepra-Krankenhaus wird freie Pflege gewährt, die Reise dahin für Patient und Pfleger wird auf Staatsmitteln bestritten. Dagegen kann der Kranke nicht gezwungen werden, ins Krankenhaus einzutreten, noch gegen seinen Willen dort zurückgehalten werden. Wenn der Kranke sich weigert, sich ins Krankenhaus zu Jerfsö aufnehmen zu lassen, ordnet der Physikus erforderliche Isolierung im eigenen Heime an, die dann von der Kommunalbehörde und dem Arzte überwacht wird. Besondere Anweisungen betreffs Desinfektion und Isolierung sind von der Medizinaldirektion im Druck herausgegeben.

In Schweden gibt es nur ein Lepra-Krankenhaus zu Jerfsö. Dies ist wie ein Siechenhaus mit ungefähr 50 Betten eingerichtet. Trotzdem die Kranken die Anstalt verlassen können, wann sie wollen, ist der Patientenwechsel im Krankenhaus nicht erheblich. Nur einige wenige Male geschieht es, dass ein Patient die Anstalt verlässt, um nicht mehr wiederzukommen; dazu trägt ganz gewiss der Umstand bei, dass im allgemeinen leicht kürzerer Urlaub zu einem Besuch in der Heimat erteilt wird.

Im Siechenhaus werden die Kranken, welche arbeiten können, mit verschiedenen Arbeiten beschäftigt und erhalten aus der Anstaltskasse als Sporn eine Entschädigung für ihre Arbeit. Bücher und Zeitungen werden für die Kranken angeschafft. Auch mancherlei Zerstreuungen werden ab und zu angeordnet. Im grossen und ganzen tut man das Möglichste, damit sie ihr trauriges Los vergessen sollen.

Das Krankenhaus liegt mitten im Lande, im grössten Lepraherde, in Helsingland, an der Eisenbahn. Der Transport der Kranken dahin erfolgt zum Teil wenigstens mit der Eisenbahn. Laut Bestimmungen werden die Kranken nur in einem besonderen Coupé befördert, das unmittelbar danach gereinigt und desinfiziert wird.

Eine grosse Schwierigkeit hier in Schweden besteht darin, dass der Glaube an die Ansteckbarkeit der Krankheit die Aufnahme von Kranken in die Kliniken zum Zwecke des Unterrichts erschwert. Indes werden alljährlich einzelne Aussätzige in den Kliniken des Karolinischen Institutes zu Stockholm beobachtet, obschon immer nur kürzere Zeit.

Serbien.

Bericht

von

J. M. Žugović in Belgrad.

Pour se rendre compte à peu-près exact, du nombre des cas de Lèpre connus et observés jusqu'à prèsent en Serbie, nous avons consulté, en fait des documents officiels, les rapports annuels de tous les hôpitaux en Serbie, depuis l'année 1880, jusqu'à l'année dernière. Outre cela, nous avons parcouru, les comptes rendus de toutes les séances de la Société médicale serbe, depuis l'origine de la Société. A part cela, vu les rapports de quelques médecins, nous adressâmes pour les renseignements nécessaires, à quelques uns de nos collègues, qui habitent les contrées où nous soupçonnions l'existence de la Lèpre. Après avoir terminé ces recherches, nous sommes arrivés aux résultats suivants:

Les cas de Lèpre constatés jusqu'à présent en Serbie, sont au nombre de quinze. De ces quinze cas, on ne peut considérer que onze, comme tout-à-fait démontrés et certains. Les quatre cas doivent être qualifiés, comme des cas de lèpre probable, parce que ces quatre cas-là, n'étaient pas vus et observés par les médecins, mais ils étaient seulement notés, d'après la description des malades et des parents des malades. Ces descriptions sont très caractéristiques et dessignent tellement bien la Lèpre, que nous les considérons comme des cas tout-à fait probables de Lèpre.

Ainsi nous enregistrons:

Les cas de lèpre tout-à-fait prouvés	11	cas
Les cas de lèpre probable	4	„
total	15	cas

Parmi les cas de lèpre probable on trouve: hommes 3 cas
femmes 1 „

Total: hommes 12 cas, femmes 3 cas.

Selon les âges: le plus jeune malade avait 15 ans et le plus âgé 52 ans.

D'après la distribution géographique de la maladie, ces malades

proviennent des différents côtés du pays. Ainsi il y avait: 7 cas au centre du pays (2 au village Kopljaré et 3 au village Stragarè-département de Kragurevaz; 2 au village Petniza-département de Valjevo); trois cas à l'Est de la Serbie, près de la frontière roumaine et bulgare (1 cas au village Dubocané, 1 au village Gamzigrad et 1 au village G. Sokolovica); 1 cas au midi de Serbie, près de la frontière macédonienne (village Trpeza à Topliza); 2 cas tout-à-fait à la frontière de Bosnie (au village Zaoviné département de Uzizé) et 2 cas à Belgrade.

Comme profession tous étaient des paysans, sauf les deux cas de Belgrade; le jeune homme était tailleur et la jeune femme couturière.

De tous ces malades, quatre hommes sont encore en vie.

Au point de vue des mesures prises contre la propagation de la lèpre, nous citons d'abord la déclaration obligatoire de la lèpre, qui date de 1890. Outre cela, un arrêté du ministre de l'intérieur oblige chaque médecin, sitôt qu'il aurait trouvé un cas de lèpre, à le transférer à l'hôpital. A l'hôpital on doit d'abord vérifier le diagnostic et ensuite garder et soigner le malade au frais de l'Etat. Vu le petit nombre des lépreux trouvés jusqu'à présent et surtout qu'il n'y avait jamais eu en même temps beaucoup de malades, l'autorité sanitaire n'avait pas besoin de créer des asiles spéciaux pour les lépreux. Ainsi en Serbie il n'y a pas d'asile spécial pour les lépreux. Il n'y a pas non plus une loie spéciale pour les lépreux, ni pour leurs internements obligatoires. Habituellement, on garde les malades atteint de lèpre, dans un hôpital de l'Etat, où ils sont isolés des autres malades. Dès qu'on découvre dans un village un nouveau cas de lèpre, immediatement l'autorité sanitaire y envoie un médecin spécial, comme expert, pour examiner le malade et toute sa famille, et il prend sur place tous les renseignements nécessaires, sur l'évolution de la maladie et les conditions hygiéniques et sociales du malade et de la contrée. Dans quelques cas, on a permis aux malades de retourner chez eux, pour se faire soigner par leurs parents. On permettait cela, dans les cas où les malades vivaient dans leurs fermes éloignées du village et des autres paysans. Dans ces cas, ces malades se trouvent sous la surveillance constante du médecin du district. Jusqu'à présent on n'a pas eu d'inconvénient de cette autorisation, car, depuis 1890 ou n'a pas remarqué de nouveaux cas de lèpre, dans les communes où vivaient les lépreux, auxquels on a permis de vivre retirés chez eux.

Siam.

Bericht

von

S. Deuntzer in Bangkok.

Ueber „den Stand der Verbreitung und der Bekämpfung der Lepra seit der ersten internationalen Leprakonferenz im Jahre 1897“ ist es leider unmöglich in Siam etwas Positives zu sagen. Statistiken irgend welcher Art gibt es einfach nicht.

Schon alte siamesische Gesetze haben das Prinzip dargelegt, dass Lepra ansteckend ist und durchgreifende Massregeln befohlen, um Ansteckung zu verhüten. Diese Gesetze sind natürlich dem Zeitpunkt ihrer Verfassung gemäss etwas barbarisch; praktisch sind sie wahrscheinlich nie durchgeführt worden.

Wo so wenig für Gesundheitswesen getan wird wie in Siam, ist geringe Hoffnung vorhanden, dass für die Bekämpfung von Lepra Massregeln getroffen werden. Die Kranken trifft man überall auf der Strasse, im Markt, auf den Trams etc. ètc., von dem Volke wird kein Widerwillen gezeigt, wenn die Fälle nicht sehr ekelerregend sind.

Nach meiner persönlichen Meinung, auf beinahe 30 jähriger Erfahrung basiert, ist Lepra sehr häufig in Siam, namentlich unter der Küstenbevölkerung; eine Zunahme habe ich nicht beobachtet; statistische Belege für meine Meinung habe ich nicht. Einen steten Zuwachs erhalten die Leprösen durch Einwanderung von Südchina; die Aussätzigen finden im reichen Siam als Bettler und Arbeiter leichter ihren Lebensunterhalt als im armen Vaterlande.

Das Vorstehende ist alles, was ich in vagen Ausdrücken und schätzungsweise über Lepra in Siam berichten kann.

Spanien.

Bericht

von

A. Pardo Regidor in Madrid.

Desde que recibí su comunicación res pecto á las cuestiones que ha de tratar el profesor Herr Neisser relacionados con la Lepra, he practicado todo género de gestiones tanto oficiales como particulares con el fin de poder facilitar el mayor número de datos al referido profesor.

En su consecuencia tengo el honor de manifestar á V. que desde el año 1897 hasta hoy no se ha hecho en España nada nuevo respecto á tan importante asunto, si bien existen proyectos para establecér en Pego (pueblo de la provincia de Alicante) una colonia Sanatorio Modelo destinada al aislamiento y curación de los lebrosos; pero hasta ahora no hay mas que el proyecto.

Lo demas establecido continua funcionando como anteriormente, sin haber esperimentado ninguna importante modificación.

Desgraciadamente y por efecto de éste retraso en las medidas contra los leprosos, la enfermedad continua lo mismo que antes y tal vez aumente hasta tal punto que según calculos aproxi mados existen en las provincias de Levante mas de mil leprosos debiendo atribuirse ésta enorme cifra, á que las disposiciones emanadas del Ministerio de la Gobernación respecto al aislamien to &, no se cumplen con el debido rigor.

Tenemos el propósito de fundar en breve una Sociedad que con la ayuda oficial se consiga extinguir, ó reducir al mínimun ésta plaga amenazadora que es una verguenza nacional.

En el Hospital de San Juan de Dios de Madrid existe un departamento de Leprosos de reciente organiszación cuyo funcionamiento con todos sus detalles se remitiran oportunamente al Congreso.

Türkei.

Bericht

von

Deycke Pascha in Konstantinopel.

Wie so manches andere in der Türkei, so befindet sich auch die Leprafrage hierzulande im Stadium absoluter Stagnation. Ich habe infolge dessen dem seiner Zeit — vor nunmehr 7 Jahren — von v. Düring auf der internationalen Leprakonferenz von 1897 erstatteten Referat im wesentlichen nichts neues hinzuzufügen: Alles ist beim Alten geblieben. Trotzdem ich von vorneherein von dem negativen Ausgang meiner Recherchen überzeugt war, habe ich mich die Mühe nicht verdriessen lassen, noch einmal Nachforschungen anzustellen über amtliche oder nichtamtliche Statistiken, über Massregeln und Regierungsverordnungen, über Tätigkeit von Behörden, Gemeinden oder Gesellschaften in der Leprafrage. Auf Grund dieser Erhebungen kann ich nur die Tatsache konstatieren, dass auch heutzutage nichts dergleichen in der Türkei besteht und demgemäss die entsprechenden Rubriken 1 und 2 des für die Berichterstattung vorgezeichneten Schemas mit einem Vakat zu versehen sind.

Diese Gleichgiltigkeit gegenüber der Lepra liegt gewiss zum Teil an der Auffassung der Nichtkontagiosität des Aussatzes, unter deren Bann gewisse medizinische Kreise und mit ihnen die in Betracht kommenden Behörden stehen; andererseits aber ist sie eine Teilerscheinung der allgemeinen Indolenz des bekannten laisser aller, laisser faire, das sich in der Türkei zu besonderer Blüte entfaltet hat. Denn mit derselben Ruhe legt man hierzulande die Hände in den Schoss gegenüber dem unaufhaltsamen Vordringen anderer Krankheitsformen, die jetzt schon in beängstigender Weise — und weit mehr als die Lepra — am Marke des Volkes nagen, ich meine da vor allem die Tuberkulose, die Malaria und die Syphilis. Ist doch selbst der von v. Düring mit vielversprechendem Erfolge inaugurierte Kampf gegen die endemische Lues in gewissen Provinzen des Reiches nach dessen Ausscheiden aus türkischen Diensten sanft und, wie ich fürchte, völlig wieder eingeschlummert und aufgegeben!

[illegible] aus den [illegible] kann [illegible] bekannt [illegible] näheren [illegible] Be[illegible] eine seh[illegible] in [illegible] Räume [illegible] des Muskat-Han[illegible] verschieden[illegible] Krankheit [illegible] traurigen [illegible] dass [illegible] der [illegible] sind, [illegible] Asyl[illegible] Röntgen[illegible] Krankenhause [illegible] Mitglieder des Lepra[illegible] aufsuchten resp. [illegible]

[illegible] Erfahrungen, die an der [illegible] werden konnten. [illegible] dem Punkt 3 des Schemas der [illegible] ist seit 6 Jahren, d. h. seit [illegible] dieses das einzige Krankenhaus [illegible] des gesamten türkischen Reiches gewesen, [illegible] aufgenommen hat und in dem wenigstens versucht wurde, die Leprösen systematisch, d. h. wie jeden anderen Kranken [illegible] zu behandeln.

[illegible] wurden bei uns in einem abseits vom Krankenhaus gelegenen Isolierraum gebettet und nach Möglichkeit der direkte oder indirekte Verkehr mit anderen Insassen des Hospitals verhindert. Wir haben dies nicht aus Prinzip getan, um unseren kontagionistischen Standpunkt zu dokumentieren, obwohl wir überzeugt sind, dass die unmittelbare Ansteckungsgefahr bei der Lepra im allgemeinen eine recht geringe ist und jedenfalls bei weitem nicht heranreicht an diejenige anderer Infektionskrankheiten wie Typhus, Dysenterie und vor allem Tuberkulose, die man, vielleicht mit Unrecht, nicht zu isolieren pflegt oder vielmehr nicht zu isolieren in der Lage ist.

In der folgenden Tabelle will ich das mir vorliegende Material solcher Leprakranken, die ich längere Zeit beobachten konnte, übersichtlich zusammenstellen.

No.	Geschlecht	Alter	Rasse	Geburtsort	Beruf	Krankheitsform	Bemerkungen
1	m.	21	Kurde	Musch (Wilayet Bitlis)	Arbeiter	Lepra tuberosa	Aeusserst schwerer Fall, multiple knotige Leprome, schwere Affektion von Mund, Gaumen, Kehlkopf und Augen.
2	m.	15	Türke	Buy-Abad (Wilayet Mastamuni)	Schüler	Lepra tuberosa	—
3	m.	16	Türke	Kir-Schehir (Wilayet Moniah)	Feldarbeiter	Lepra maculo-anaesthetica	—
4	m.	21	Türke	Kreta	Offiziersaspirant, Schüler der Ecole préparatoire militaire	Lepra tuberosa	Ganz im Beginn stehender Fall. Pat. hat als einzige Zeichen der Lepra ein typisches knotiges Leprom auf der rechten Wange und ein psoriatiformes Exanthem von ca. Handgrösse auf der Aussenseite des rechten Oberschenkels. Das exstirpierte Leprom sowohl wie ein Stück der affizierten Haut des Oberschenkels enthielten massenhaft Leprabazillen.
5	m.	40	Türke	Afiun-karabissar (Wilayet Angora)	Arbeiter	Lepra tuberosa	—
6	m.	22	Türke	Tokad (Wilayet Liwas)	Landmann	Lepra tuberosa	—
7	m.	20	Türke	Mastamuni	Arbeiter	Lepra anaesthetica	—
8	m.	20	Türke	Trapezunt	Arbeiter	Lepra mutilans	—
9	m.	37	Türke	Giressun (Wilayet Trapezunt)	Arbeiter	Lepra tuberosa	—
10	m.	31	Türke	Nigude (Wilayet Moniah)	Wachsoldat	Lepra tuberosa	—
11	m.	16	Grieche	Constantinopel	Schuhmacher	Lepra tuberosa	Patienten sind Brüder, deren Erkrankung etwa gleichweit vorgeschritten ist. Knotige Form besonders im Gesicht. Die Mutter ist gesund und frei von Lepra (Okularinspektion!). Vater an unbekannter Krankheit gestorben, war nicht leprös. Auch sonst keine hereditäre oder familiäre Belastung nachweisbar. Pat. behaupten, nie mit Leprösen sonst in Kontakt gekommen zu sein. Beide sind hier geboren und haben die Hauptstadt nie verlassen.
12	m.	18	Grieche	Constantinopel	Schuhmacher	Lepra tuberosa	
13	m.	55	Jude (Spaniole)	Constantinopel	Glaser	Lepra anaesthetica mutilans	Mutilierungen an Fingern und Zehen, schwere Augenaffection.
14	m.	30	Jude (Spaniole)	Constantinopel	Trödler	Lepra tuberosa	—

No.	Geschlecht	Alter	Rasse	Geburtsort	Beruf	Krankheitsform	Bemerkungen
15	m.	22	Jude (Spaniole)	Konstantinopel	Kolporteur	Lepra tuberosa	Im Hospital an Nephritis gestorben. Multiple, im Gesicht zum Teil eitri schmolzene Leprome, die in ganz un Mengen Leprabazillen enthalten. Im Blut (sowohl intra vitam als auch post sehr zahlreiche Leprabazillen, daneben konnten überall auf Blutagar Diphtheri züchtet werden. Embolie der linken Art. pulmonalis. Nephritis parenchymatosa Oedeme beider Beine, Hydrocephalus externums, meningeale flächenhafte Blutunge Schädelbasis (auch in diesen Blutungen Leprabazillen).
16	m.	52	Rumän. Jude	Constantinopel	Dolmetsch.	Lepra tuberosa	Im Hospital gestorben. Sektion kon gemacht werden.
17	w.	30	Türkin	Kanguri (Wilayet Mastamuni)	Insassin d. Lepraasyls in Skutari	Lepra tuberosa et mutil.	—
18	w.	21	Türkin	Kanguri (Wilayet Mastamuni)	Insassin d. Lepraasyls in Skutari	Lepra tuberosa	—
19	w.	20	Türkin	Kanguri (Wilayet Mastamuni)	Insassin d Lepraasyls in Skutari	Lepra tuberosa	Gestorben im Hospital. Sektion: Z Leprome über den Körper mehr oder dicht verstreut, besonders zahlreich im (Leontiasis insipiens). Tod an Tuberku zwar fand sich Tuberkulose der Lu Peritoneums, der Mesenterialdrüsen und des grossen Netzes. Die tuberkulöse Nat Prozesse wurde histologisch durch die typische Tuberkelbildung und den relativ Gehalt an Bazillen (gegenüber dem ungeheuren Reichtum an Leprabazillen in d lepromen) schon sehr wahrscheinlich gemacht, strikt bewiesen aber durch In eines Kaninchens vermittelst eines Stücks einer verkästen Mesenterialdrüse. I suchstier starb nach $2^1/_2$ Monaten an typischer generalisierter Tuberkulose.
20	w.	27	Tartarin	Krim	Wäscherin	Lepra tuberosa	—
21	m.	35	Türke	Afinu-Karahissar (Wilayet-Angora)	Arbeiter	Lepra tuberosa	Sehr schwerer vorgeschrittener Fall, knotige Leprome, unförmliche Vergr beider Ohren, abgeplattete stark verbrei verdickte Nase, starke pralle Schwell linken Unterschenkels, Affektion des und Kehlkopfes etc.; unregelmässig intermittierendes Fieber, Neuralgieen. — verschiedenen Lepromen konnte eine säurebeständige Streptothrixart in R isoliert werden (vgl. unten). Mit Injektionen dieser Kulturen behandelt und schreitender Heilung überraschend gebessert entlassen.
22	m.	24	Türke	Bolu (Wilayet-Mastamuni)	Arbeiter	Lepra tuberosa	Erwähnenswert auf jedem Auge je ein das vom Corneallimbus auf die Hornha greift. Histologisch in demselben enorme Mengen von überwiegend und intrazellulär gelagerten Leprabazillen. thrixbehandlung vor kurzem begonne bereits deutliche Besserung besonders stehenden Schleimhautlepra des Mundes e
23	m.	35	Türke	Kreta	Arbeiter	Lepra tuberosa	Sehr zahlreiche, vielfach sehr oberfläch kutan geleg. knotige Leprome, besond. aus am Rücken. Nur kurze Behandl. mit Stre injekt. lässt doch eine sichtliche Rückbildung u. Verkleinerung d. leprösen Knoten b

	Alter	Rasse	Geburtsort	Beruf	Krankheitsform	Bemerkungen
ı.	32	Kurde	Erzerum	Arbeiter	Lepra tuberosa	Pat. wird noch jetzt mit Streptothrixinjektione behandelt, die in wenigen Wochen seine aus gedehnten Hautaffektionen zum Verschwinde gebracht und eine lepröse Infiltration de Larynx deutlich gebessert haben.
ı.	22	Kurde	Erzerum	Arbeiter, später Insasse des Lepraasyls in Skutari	Lepra tuberosa	Pat. war zweimal im Hospital. Das letzt Mal wurde er kurze Zeit mit Streptothri injektionen behandelt, die bestehendes Fiebe beseitigten und die ausgedehnten Schleimhaut affektionen des Gaumens und Rachens seh günstig beeinflussten.
ı.	50	Russischer Jude	Krim	Synagog.-diener	Lepra maculo-tuberosa	Enorm ausgedehnte, violett gefärbte und ir filtrierte, vielfach landkartenartig verteilt Flecke im Gesicht und am ganzen Rumpf, zu Teil von gewaltiger Grösse. Ambulante Be handlung mit Streptothrixinjektionen bewirk eine ununterbrochen fortschreitende Rückbildun der ausgedehnten Processe.

Bei dem völlig negativen Ausgang meiner Erhebungen in Bezug auf Abwehr und Verhütung des Aussatzes in der Türkei, drängte sich mir um so lebhafter der Wunsch auf, wenigstens persönlich und zunächst rein wissenschaftlich der Leprafrage Terrain abzugewinnen. Ich nahm im Frühjahr dieses Jahres in Gemeinschaft mit meinem Assistenten und Mitarbeiter Reschad Bey frühere durch andere Arbeiten unterbrochene Versuche wieder auf, den Leprabazillus auf künstlichen Nährmedien zu züchten. Ich weiss nicht, ob mir die schon oft, aber wie ich auf Grund der mir vorliegenden Literatur glaube, bisher vergeblich gesuchte Lösung dieses Problems gelungen ist. Immerhin aber haben die noch im vollen Fluss befindlichen Untersuchungen soviel des Interessanten zu Tage gefördert, dass ich die bisherigen Ergebnisse dem Rahmen meines Referats kurz einfügen möchte.

Der erste Kranke, den wir nach dieser Richtung hin systematisch untersuchten, war der sub 21 meiner Tabelle genannte. Es handelte sich um eine sehr schwere und ausgedehnte knotige Lepra, die sich im Eruptionsstadium befand, dokumentiert durch wochenlang ($7\frac{1}{2}$ Woche) anhaltendes intermittierendes Fieber, schweren Allgemeinzustand und Auftreten neuer Knoten und Infiltrationen.

Wir sind nun nach zahlreichen anderen vergeblichen Versuchen so vorgegangen, dass wir diesem Patienten Theile von Lepromen steril exstirpierten oder vielmehr subkutan herausschälten und diese, enorme Mengen von Leprabazillen enthaltenden Stücke einfach in sterilisierte physiologische Kochsalzlösung übertrugen. Die im Brutofen wochen- und monatelang gehaltenen Röhrchen wurden von Zeit zu Zeit mikroskopisch untersucht, und dabei zeigte sich in einigen wenigen von zahlreichen Kulturproben, und zwar frühestens nach etwa 14 Tagen, die Entwickelung eines eigenartigen und bislang unbekannten säure-

beständigen Mikroorganismus. Das Wachstum erfolgte entweder um die leprösen Gewebsteile herum, so dass dann das betreffende Stück von einem makroskopisch kaum sichtbaren Flaum umgeben war, oder aber die Organteile zerfielen und aus den Bröckeln entwickelten sich pilzdrusenähnliche Reinkulturen des Mikroben, der sich als eine echte Streptothrixart mit sich verzweigenden Fäden darstellt. Nur in solchen Röhren konnte das Auftreten dieser Gebilde beobachtet werden, die im Uebrigen mikroskopisch wie kulturell dauernd steril geblieben waren, so dass es sich in jedem Falle um eine absolute Reinkultur handelte. Von einer zufälligen Verunreinigung kann schon deshalb nicht die Rede sein, weil es uns zu ganz verschiedenen Zeiten und aus drei verschiedenen Lepromen desselben Kranken gelang, den gleichen Mikroben nachzuweisen und, wie man gleich sehen wird, auch reinzuzüchten. Auch der Umstand verdient Beachtung und charakterisiert unsere Streptothrixart, dass wir in gewissen Entwickelungsstadien sehr leicht und des öfteren unter dem Mikroskop feststellen konnten, wie die verzweigten Fäden aus dem Innern von Leprabazillenglobi herauswuchsen und diesen dann bisweilen hirschgeweihähnlich aufsassen.

So mühevoll und reich an Misserfolgen, ja geradezu Geduld erschöpfend die erste Aufzucht der Streptothrixart war, so leicht gestaltete sich ihre Isolierung und Weiterzüchtung auf den üblichen Nährböden. Auf gewöhnlichem Agar erschienen nach 3—4 Tagen kleinste Kolonien, die mikroskopisch auf der Platte ein strahliges Fadengefüge präsentieren und ein eigentümlich starkes Lichtbrechungsvermögen besitzen, so dass man sie ebenso deutlich bei ganz geöffneter Blende wie bei starker Abblendung betrachten kann. Werden die Kolonieen etwas grösser, dann erhalten sie gewissermassen einen zentralen Kern und es gibt zur Illustration ihres Aussehens kaum einen besseren Vergleich, als an die Konfiguration gewisser Astrozyten der Neuroglia zu erinnern. Bei längerem Wachsthum wird der Kern und auch der strahlige Teil der Kolonie immer grösser und ersterer nimmt eine sehr deutliche schöne Orangefärbung an. Immer haften die Kolonieen sehr fest auf der Agaroberfläche, sodass es mitunter nicht ganz leicht ist, mit der Platinnadel Material zur mikroskopischen Untersuchung und zur Aussaat zu bekommen. Bei älteren Kulturen beobachtet man stets ein Einwachsen in die Tiefe des Agars, ähnlich wie das bei gewissen Pilzarten statt hat.

An Stelle des gewöhnlichen Agars wandten wir späterhin fast ausschliesslich einen Nähragar an, den wir aus menschlichem Gehirn bereitet hatten; auf diesem war das Wachstum sowohl üppiger als auch vor allem schneller, meist schon nach 24 Stunden, sicher aber nach 48 waren deutliche Kolonieen sichtbar. In Agarstichkulturen wächst unsere Streptothrixart ebensogut wie auf der Oberfläche des Nährbodens.

Von übrigen Nährmedien mussten wir einstweilen von Gelatine, die hier zu Lande in der Sommerszeit kaum anwendbar ist, absehen. Dagegen ist das Wachstum in Bouillon ungemein charakteristisch. Es bilden sich da, freilich nur langsam und erst nach mehreren Tagen eigentümliche pilzdrusenähnliche Gebilde, die oft nach einiger Zeit ein dichteres orangefarbenes Zentrum erkennen lassen. Die Drusen, in

einer Bouillonkultur meist nur wenige an der Zahl, sammeln sich am Boden des Reagenzglases und die darüber stehende Bouillon bleibt völlig klar. Bisweilen können die einzelnen Streptothrixballen eine sehr beträchtliche Grösse erreichen, wir haben solche bis Erbsengrösse gesehen. Wenn man sich bemüht, möglichst viel Material in ein Bouillonröhrchen zu übertragen und das lässt sich am besten durch mehrfaches Abstreichen älterer Agarkulturen erreichen, dann bildet sich ein mehr flockiger Bodensatz, der sich aus mikroskopisch kleinen Drusen zusammensetzt.

In morphologischer Beziehung ist noch zu sagen, dass unser Mikrobe unbeweglich, grampositiv und für alle Modifikationen säurebeständig ist. Das letztere gilt zumal für jüngere Kulturen; in älteren büssen die Fäden zuerst partiell und graduell an Azidoresistenz ein und degenerierende resp. absterbende Fäden färben sich mit der Kontrastfarbe. Dagegen sind die gewissermassen bazillären Enden der Fäden stets durchaus säurebeständig und sie sind es, welche morphologisch unsere Streptothrixart zumal in älteren Kulturen den echten Lepraerregern wieder näher bringen. Während sie anfänglich den verzweigten Fäden als ihre Endteile einfach und scheinbar ohne Unterbrechung aufsitzen, dabei nicht selten eine leichte kolbige Verdickung ihres peripheren Endes zeigen, lösen sie sich bei Untersuchung älterer Kulturen ab und präsentieren sich dann als säurebeständige Bazillen, die neben lepraähnlichen Formen meist etwas kleinere und plumpere Bildungen zeigen als die Leprabazillen im Gewebe, die ja übrigens auch recht verschiedene Konfiguration besitzen können. Ja wir haben bei einem Leprafall beobachtet, dass dort fast sämtliche Bazillen auffallend klein und auch dicker erschienen, als man es sonst zu sehen gewohnt ist.

Aus dieser keineswegs erschöpfenden Beschreibung erhellt wenigstens das Eine mit absoluter Sicherheit, dass der von uns gefundene und rein kultivierte Mikroorganismus nicht identisch ist mit den von anderen Forschern und auch von uns vielfach gezüchteten Diphtherideen. Aber andererseits sind wir uns auch darüber klar, dass der Beweis der Identität zwischen den echten Leprabazillen und unseren Streptotricheen nicht erbracht ist. Denn bei zwei weiteren Leprafällen, die daraufhin mit vieler Geduld und Ausdauer untersucht wurden, konnte derselbe weder mikroskopisch noch kulturell konstatiert werden. Freilich waren diese beiden Fälle (No. 23 und 24) nach unserer jetzigen Auffassung wenig geeignet. Beides waren nicht floride Krankheitsformen ohne Fieber und ohne neue Eruptionen und bei beiden gelang es kaum ein einziges Mal, unter zahlreichen Versuchen, ein in Bezug auf andere Bakterien steriles Röhrchen zu erhalten. Entweder waren dieselben zufällig verunreinigt, was sich begreiflicherweise nicht immer vermeiden lässt, oder aber wir fanden in Reinkultur die eben erwähnten Diphtherideen. Nach unseren bisherigen Erfahrungen halten wir es aber für ausgeschlossen, dass die fragliche Streptothrixart bei Anwesenheit anderer Keime überhaupt zum Wachstum zu bringen ist. Immerhin ist der Befund an Diphtherideen, und zwar sowohl von säurebeständigen wie von säureunbeständigen, ein so häufiger bei Lepra-

fällen, dass man da in der Tat an echte Bakterienassoziationen denken muss.

So waren wir darauf angewiesen, andere Indizien für eine etwaige spezifische Bedeutung unserer Streptotricheen aufzusuchen. Tierexperimente haben uns bis zum heutigen Tage völlig im Stich gelassen; es scheint, dass unser Mikroorganismus überhaupt nicht tierpathogen ist, was in Analogie zu dem gleichen Verhalten des echten Leprabazillus stehen würde. So entschlossen wir uns denn, dem ersten Patienten, von dem die Streptothrixart stammte und dem wir über 10 Leprome exstirpiert und damit ungeheure Mengen von Leprabazillen eliminiert hatten, eine kleine Quantität unseres Mikroben in vivo subkutan einzuspritzen. Wir wählten dazu eine kleine, in Bouillon gewachsene drusenähnliche Kolonie, wie ich sie oben geschildert habe. Der Erfolg dieser Injektion war ein sehr merkwürdiger und jedenfalls nicht der erwartete. Am Tage nach der Injektion empfing uns der Patient mit der überaus freudig vorgebrachten Mitteilung, wir hätten ihm da endlich einmal ein gutes, wirksames Heilmittel eingespritzt. Wir hielten das natürlich für eine suggestive Wirkung, aber es war auffallend, dass einmal die Temperatur, die seit über 7 Wochen zwischen 39,5 und 37° schwankte, den ganzen Tag normal blieb; ferner bestand der Patient hartnäckig darauf, dass im Anschluss an die Injektion die neuralgiformen Schmerzen in dem betreffenden Arm, die ihn sehr gequält und bereits Morphiumapplikation erfordert hatten, spurlos verschwunden seien. Lokal zeigte sich an der Injektionsstelle zunächst rein gar nichts; dann, nach 3 Tagen, bildete sich eine subkutane, ziemlich harte Induration ohne entzündliche Erscheinungen, die kaum Markstückgrösse erreichte, ca. 10 Tage bestand, um dann sich völlig zu verziehen.

Da Pat. uns täglich bestürmte, die Injektion zu wiederholen, und da sehr auffälliger Weise seit dem Tage der Injektion die Temperatur dauernd normal blieb, so wiederholten wir die Einspritzung nach Ablauf einer Woche in derselben Weise. Resultat: derselbe lokale Befund und die gleiche günstige Reaktion auf das subjektive Befinden und den Allgemeinzustand. Wir haben dann die Injektionen öfter folgen lassen, erst 2mal, später sogar bis zu 3mal pro Woche. Im ganzen erhielt Pat. in 6 Wochen 12 Einspritzungen. In dieser Zeit blieb die Temperatur normal; Pat., der vorher in recht miserablem Allgemeinzustande sich befunden hatte, erholte sich sichtlich, sämtliche Lepromknoten der Haut bildeten sich zurück, die meisten verschwanden ganz, bei anderen grösseren blieb eine verhärtete Narbe; eine ausgedehnte pralle Schwellung des ganzen linken Unterschenkels verzog sich in ganz kurzer Zeit, die geradezu grotesk verunstalteten und enorm vergrösserten Ohrmuscheln bildeten sich um die Hälfte ihres Umfanges zurück, lepröse Affektionen der Gaumenschleimhaut flachten ab und heilten unter Zurücklassung von nicht prominenten bläulich-milchigen Narben. Kurzum, das klinische Bild war wie umgewandelt, und die Besserung kam einer Heilung der leprösen Symptome, wohlverstanden nicht der Lepra, sehr nahe. Leider war es nicht möglich, den Patienten länger im Krankenhause zu halten, da er sich selber für völlig geheilt und gesund hielt.

Nach der etwas ausführlicheren Schilderung des ersten Falles kann ich mich mit den übrigen fünf, auf dieselbe Weise behandelten Lepra-

kranken kurz fassen, da es im Rahmen dieses Referats naturgemäss nur meine Aufgabe sein kann, ein Uebersichtsbild zu zeichnen.

Zwei Kranke (No. 23 und 25), die sich deutlich gebessert hatten, haben leider das Krankenhaus nach wenigen Einspritzungen verlassen, der eine, weil er zu seiner Familie nach Kreta zurückkehren wollte; der andere entzog sich der Behandlung durch eine schlau bewerkstelligte Flucht, nach gelegentlichen Aeusserungen zu schliessen deshalb, weil er, so unglaublich das klingen mag, fürchtete, völlig von seiner Krankheit geheilt zu werden. Pat. ist nämlich Insasse des Miskin-Hane in Skutari und als solcher professioneller Bettler, der den Verlust der Lepra und ihrer sinnfälligen Symptome mit dem Verlust seines Broterwerbs gleichsetzte, — auch ein ganz interessanter volkspsychologischer Beitrag!

Ein dritter noch in Behandlung befindlicher Kranker (No. 23) ist nach 11 Injektionen so weit gebessert, dass die bis Fünfmarkstück grossen Infiltrationen, mit denen der ganze Rumpf fast lückenlos übersäet war, mit Ausnahme leichter undeutlicher Pigmentierungen sich spurlos aufgelöst haben und dass eine mit völliger Aphonie einhergehende infiltrierende Larynxlepra sich wesentlich zurückgebildet hat, so dass Patient jetzt wieder, wenn auch noch mit rauher Stimme sprechen kann.

Ein vierter Patient (No. 26) litt an geradezu enorm ausgedehnten, violettfarbigen, über die normale Haut stark vorspringenden und derb infiltrierten leprösen Affektionen, die das ganze Gesicht und den ganzen Rumpf — dort landkartenähnlich ausgebreitet —, sowie beide Arme befallen hatte. Nach 10 Einspritzungen sind jetzt sämtliche Plaques in prompter Rückbildung begriffen, die Infiltrationen sind fast verschwunden und überall treten bereits handtellergrosse Bezirke von normaler Haut auf. Bei diesem Patienten war ein Vorfall interessant. Aus Mangel an anderem Impfmaterial wurde ihm eines Tages Bouillonkultur von der oben geschilderten flockigen Beschaffenheit, also viel grössere Mengen an lebenden Streptothricheen injiziert; er reagierte darauf mit einer sehr ausgesprochenen Schwellung und Injektion der sämtlichen leprösen Plaques. Die übrigens rein lokale Reaktion, die also nicht von Allgemeinerscheinungen wie Fieber etc. begleitet war, gemahnte auf das prägnanteste an das Bild einer lokalen Tuberkulinreaktion bei Hautlupus.

Der fünfte und letzte, erst seit kurzem in Behandlung befindliche Patient (No. 22), zeigt bis jetzt Besserung, zumal der bei ihm bestehenden leprösen Gaumenaffektion und Verkleinerung der bei ihm nur vereinzelt vertretenen Hautleprome. Interessant war, dass zweimal nach einer Injektion an der Inokulationsstelle sich im Laufe von zwei Tagen ein kleiner nur wenige Tropfen Eiter enthaltender Abszess gebildet hatte, der nach Ausdrücken des Eiters sofort in weiteren zwei Tagen abheilte. Im Eiter fanden sich keine Eiterkokken, nur sehr spärliche säurebeständige Bazillen, wahrscheinlich echte Lepraerreger, und nur in einem Präparat ein einziges Konvolut säurebeständiger Fäden, das zweifellos trotz negativen Kulturversuches den von uns injizierten Streptothricheen angehörte. Daraus scheint also hervorzugehen, dass die lebenden Streptothricheen im Körper sehr schnell aufgelöst werden,

vielleicht ein Anhaltspunkt zur Erklärung ihrer therapeutischen Wirkung.

Das dürfte im grossen und ganzen dasjenige sein, was wir bisher beobachtet haben und was ich bei dieser Gelegenheit bekannt geben möchte. Ich bin mir am besten bewusst, dass erst Prüfungen an einem viel grösseren Material, als es mir zur Zeit zu Gebote steht, das entscheidende Wort über die allgemeine Giltigkeit unserer Erfahrungen sprechen werden. Immerhin schien mir, zumal im Hinblick auf die sonstige Trostlosigkeit der Lepratherapie, auch das Wenige, was wir einstweilen zur Lösung des trotz vieler Fortschritte noch sehr dunklen und schwierigen Problems beitragen konnten, Wert und Interesse in genügendem Masse zu besitzen, um schon jetzt die Aufmerksamkeit eines weiteren wissenschaftlichen Kreises auf unsere Versuche zu lenken.

Um Missverständnissen vorzubeugen, möchte ich das Resultat unserer bisherigen Studien abschliessend noch einmal dahin präzisieren, dass wir aus drei Lepromen eines Falles schwerer tuberöser Lepra eine wohlcharakterisierte und bislang unbekannte säurebeständige Streptothrixart isoliert und reingezüchtet haben, die, lebend demselben und fünf anderen Leprakranken (im ganzen also sechs Patienten) injiziert, bei allen eine deutliche, bei mehreren eine sehr weit gehende Rückbildung, Besserung und zum Teil sogar Heilung von leprösen Affektionen gezeitigt haben. Ich wiederhole ausdrücklich, es handelt sich einstweilen um die günstige Beeinflussung lepröser Symptome, nicht um die der konstitutionellen Lepra.

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